

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

4862

4883548

Reg. Dist. No.

4862

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md b. COUNTY HARTFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale	c. LENGTH OF STAY IN 1b transient	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RFD Whiteford) Bel Air 12322	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 124 N Main St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William Elgie Allison		4. DATE OF DEATH Month Day Year May 22 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-33
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Truck Driver	11. BIRTHPLACE (State or foreign country) Hartford
12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME Guy Allison		14. MOTHER'S MAIDEN NAME Gertrude Lowe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-30-2754	
17. INFORMANT Mrs Billie E Allison 124 N Main St Bel Air Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Skull--Auto Accident DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) 816X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Inst			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pinned in cab of truck which ran into tractor trailer	
20c. TIME OF INJURY Month, Day, Year Hour 8:45 a.m. 5-22 1957	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street	20f. (City or town) (County) (State) Rosedale Balto Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John C Hyle		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John C Hyle		DATE SIGNED 5-22-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 25/57	22c. NAME OF CEMETERY OR CREMATORY Bell Air Memorial Gardens Bel Air Harford Md	22d. LOCATION (City, town, or county) (State) Bel Air Harford Md
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Ford		24a. REC'D BY REGISTRAR MAY 27 1957	
		24b. REGISTRAR'S SIGNATURE Edith G. Guley	

BUREAU V. S.

MAY 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4866 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04836
45

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <div align="center">Baltimore</div>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <div align="center">Md</div> b. COUNTY <div align="center">Baltimore</div>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div align="center">Essex</div>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <div align="center">Frederick Carl Ammons</div>		4. DATE OF DEATH Month <div align="center">May</div> Day <div align="center">31</div> Year <div align="center">19 57</div>	
5. SEX <div align="center">male</div>	6. COLOR OR RACE <div align="center">white</div>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <div align="center">Jan 14 1936</div>
9. AGE (In years last birthday) <div align="center">21 yrs.</div>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div align="center">steel worker</div>		10b. KIND OF BUSINESS OR INDUSTRY <div align="center">Beth Steel</div>	
11. BIRTHPLACE (State or foreign country) <div align="center">Baltimore Co</div>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <div align="center">Albert Ammons</div>		14. MOTHER'S MAIDEN NAME <div align="center">Josephine ?</div>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <div align="center">Mrs Josephine Ammons</div>		Address <div align="center">7057 Dunbar Road</div>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound multiple fractures</u> 816x DUE TO <u>(Skull, Spinal column, Thoracic cage)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Perforation abdominal wall</u> (c) _____</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hit a truck with an estimated speed of 100 MILES</u>	
20c. TIME OF INJURY Month, Day, Year <div align="center">2:30 a.m. 5-31 1957</div>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>EASTERN BLVD</u>	20f. (City or town) (County) (State) <u>ESSEX, BALTO MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W.E. Baermann</u>		DATE SIGNED <u>5/31/57</u>	
EXAMINER'S NAME (Type) <u>W.E. BAERMANN</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>June 3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	
22d. LOCATION (City, town, or county) (State) <u>Baltimore Co MD</u>		24a. REC'D BY REGISTRAR <u>6/3/57</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ulrich Funeral Home</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Kurliga</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUN 4 1957
BUREAU V. F.

4864

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		d. STREET ADDRESS 1905 Wilhelm St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Tressian Middle Anderson Last Anderson		4. DATE OF DEATH Month 5 Day 31 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-13-05
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Writer-Salesman		10b. KIND OF BUSINESS OR INDUSTRY Automobiles	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alonzo Anderson		14. MOTHER'S MAIDEN NAME Lillie Mules	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-09-0768	
17. INFORMANT Charles Anderson		Address 2403 Barclay St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pharynx with metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 26 , 19 57 to May 31 , 19 57 , that I last saw the deceased alive on May 31 , 19 57 , and that death occurred at 11:50 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Stella Wachter M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	June 4-57	Druid Ridge Cemetery	Pikesville Md
23. FUNERAL DIRECTOR'S SIGNATURE Frank W. Leitz		ADDRESS 814 W 36th St.	24a. REC'D BY REGISTRAR DATE JUN 4 57
		24b. REGISTRAR'S SIGNATURE Quinn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF BIRTH <i>1912-03-15</i>		PLACE OF BIRTH <i>John Doe, Maryland</i>	
MARRIAGE <i>Married</i>		EDUCATION <i>High School</i>		OCCUPATION <i>Teacher</i>		RELIGION <i>Methodist</i>		MANNER OF DEATH <i>Natural</i>		CAUSE OF DEATH <i>Heart Disease</i>	
DATE OF DEATH <i>1957-06-10</i>		PLACE OF DEATH <i>John Doe, Maryland</i>		TIME OF DEATH <i>10:00 AM</i>		TEMPERATURE <i>Normal</i>		PULSE <i>Normal</i>		RESPIRATION <i>Normal</i>	
SIGNATURE OF PHYSICIAN <i>John Doe, M.D.</i>		SIGNATURE OF CORONER <i>John Doe, M.D.</i>		SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	
DATE OF SIGNATURE <i>1957-06-10</i>		DATE OF SIGNATURE <i>1957-06-10</i>		DATE OF SIGNATURE <i>1957-06-10</i>		DATE OF SIGNATURE <i>1957-06-10</i>		DATE OF SIGNATURE <i>1957-06-10</i>		DATE OF SIGNATURE <i>1957-06-10</i>	

BUREAU V. &

JUN 2 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04838

Reg. Dist. No.

4865

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>4yr 10m 20dys</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>E.</u> Last <u>Appel</u>				4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March ?, 1866</u>	9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>press hand</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Crown, Cork & Seal</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Appel</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Henze</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>220-87-5453</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>443X Fracture of left hip</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt. fell to floor on 5-7-57 sustaining fractured left hip.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>5-7-57 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>		20f. (City or town) (County) (State) <u>Catonsville 28, Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo M Kieffer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 18-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem Hampden</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank X. Seitz</u> ADDRESS <u>814 1/2 36th St</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 17 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Alv. Carich</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Burial, cremation, or removal.

AY 20 1957

RECEIVED

4866

CERTIFICATE OF DEATH

04839

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7 3V01.4 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paradise Nursing Home Paradise and Altamont Aves.				d. STREET ADDRESS 5314 Wayne Ave.			
3. NAME OF DECEASED (Type or print) First JONATHAN Middle S. Last ARCHER				4. DATE OF DEATH Month May Day 23 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1875		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rtd. Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Archer				14. MOTHER'S MAIDEN NAME Mary E.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Ruth S. Archer - 5314 Wayne Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cardiovascular disease DUE TO (c) C.P.D. Lung & Kidney & Edema of 9th hr							INTERVAL BETWEEN ONSET AND DEATH 1 hr 1 year 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 10 , 19 55 , to May 23 , 19 57 ; that I last saw the deceased alive on May 24 , 19 57 , and that death occurred at 9:10 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE D. E. ... M.D.				ADDRESS (Street, city or town, state) 6 East ...		DATE SIGNED May 24/57	
PHYSICIAN'S NAME (Type) Dr. E. W. ...							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/27/57		22c. NAME OF CEMETERY OR CREMATORY Fernwood Cen.		22d. LOCATION (City, town, or county) (State) Philadelphia, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. ...				ADDRESS ...		24a. REC'D BY REGISTRAR DATE 5/27/57	
				24b. REGISTRAR'S SIGNATURE A. H. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

452

28 MAY 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 , 4867
 CERTIFICATE OF DEATH

04840

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Batonville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Lines</u>				d. STREET ADDRESS <u>1833 Linden Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>KATE</u> Middle <u>ASKIN</u> Last				4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>		11. BIRTHPLACE (State or foreign country) <u>Lynchburg Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Frank Askin</u>				14. MOTHER'S MAIDEN NAME <u>Dorah Belle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Morton Askin-606 E. Lombard</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer on a of Colon</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>56</u> , to <u>May 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 2</u> , 19 <u>57</u> , and that death occurred at <u>12:37</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. M. S. Shilling</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>2500 Eutaw Place 5/4/57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. M. S. Shilling</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-8-57</u>		<u>B'nai Israel</u>		<u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Jack Lewis Inc 2100 Eutaw Pl</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 6 57</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

BUREAU V. S.

6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4863

CERTIFICATE OF DEATH

Reg. Dist. No.

04841

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HEREFORD</u>		c. LENGTH OF STAY IN 1b <u>21 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MONKTON RD</u>		d. STREET ADDRESS <u>1 MONKTON RD.</u>	
3. NAME OF DECEASED (Type or print) <u>SAMUEL WILTON</u> First Middle Last		4. DATE OF DEATH <u>MAY 27</u> Month Day Year	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 3 - 1903</u>	
9. AGE (In years lost birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		12. KIND OF BUSINESS OR INDUSTRY <u>GEN. MERCHANDISE</u>	
13. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. FATHER'S NAME <u>JAMES UPTON AYRES</u>		16. MOTHER'S MAIDEN NAME <u>MARY MULLINEAUX</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		18. SOCIAL SECURITY NO. <u>AMENIA-K-AYRES</u>	
19. INFORMANT <u>AMENIA-K-AYRES</u>		Address <u>MONKTON RD. - HEREFORD</u>	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		22d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22f. (City or town) (County) (State)	
23. I certify that I attended the deceased from <u>MAY 15</u> , 19 <u>57</u> , to <u>MAY 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MAY 27</u> , 19 <u>57</u> , and that death occurred at <u>1:30</u> P.M., from the causes and on the date stated above.		24. ADDRESS (Street, city or town, state) <u>Parkton, Md.</u>	
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		DATE SIGNED <u>5/27/57</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		<u>PARKTON MD</u>	
25a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		25b. DATE THEREOF <u>5-30-57</u>	
25c. NAME OF CEMETERY OR CREMATORY <u>AYRES CHAPEL CHY</u>		25d. LOCATION (City, town, or county) (State) <u>NEAR-SHAWSVILLE MD.</u>	
26. FUNERAL DIRECTOR'S SIGNATURE <u>Wm COOK-TOWSON, INC.</u>		ADDRESS <u>1050 N. YORK RD.</u>	
27a. REC'D BY REGISTRAR <u>5/28/57</u>		27b. REGISTRAR'S SIGNATURE <u>Chester L. Fulton</u>	

CERTIFICATE OF DEATH

MD 50-104

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BUREAU V. S.

MAY 29 1957

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Vertical text on the right edge of the page, possibly a date stamp or filing information.

4841

CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				c. LENGTH OF STAY IN 1b <u>53</u> <u>Dundalk</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3415 Yorkway</u>				d. STREET ADDRESS <u>1 3415 Yorkway</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Caroline M. Ballardarsch</u>				4. DATE OF DEATH Month Day Year <u>May 9th 19 57</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1880</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernest Meister</u>				14. MOTHER'S MAIDEN NAME <u>Greasman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mr. John V. Ballardarsch, 3415 Yorkway</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Parasomnia of stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 7</u> , 19 <u>57</u> , to <u>May 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 9</u> , 19 <u>57</u> , and that death occurred at <u>11 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel Harkin</u> M.D.				ADDRESS (Street, city or town, state) <u>3479 Liberty Park</u>		DATE SIGNED <u>5/10/57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Samuel Harkin</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/13/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR DATE <u>5/14/57</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. M. Kelly, Jr.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4869

CERTIFICATE OF DEATH

04843

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gwynn Oak		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3011 Oak Hill Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRED Middle CURTIS Last BARKER		4. DATE OF DEATH Month May Day 19 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1871
9. AGE (In years last birthday) 85		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Newspaper	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edwin Wythe Barker		14. MOTHER'S MAIDEN NAME Lorilla Daine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mes. Olivia H. Barker - 3011 Oak Hill Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Congestive Cardiac Failure (c) Arteriosclerosis (General)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1950 , to May 19, 1957 , that I last saw the deceased alive on May 19, 1957 , and that death occurred at 8 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward J. Warner		DATE SIGNED 5-20-57	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) 2604 Garrison, Phila. (Pa.)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5/22/57	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Crem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickener & Sons - Balto.		24a. REC'D BY REGISTRAR DATE 5/22/57	
ADDRESS Md.		24b. REGISTRAR'S SIGNATURE Dr. Wm. Martin	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4870

CERTIFICATE OF DEATH

04844

Reg. Dist. No. 43

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4100 Taylor Ave.		d. STREET ADDRESS 4100 Taylor Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Minnie Middle J. Last Barth		4. DATE OF DEATH Month May Day 21 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1886
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR: Months 71 Days 13 Hours 15 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John H. Kiefer		14. MOTHER'S MAIDEN NAME Mary S. Hoerning	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Marie A. Barth		Address 4100 Taylor Ave. 6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x cerebral hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertensive vascular disease (c) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 13, 1957 to May 17, 1957 , that I last saw the deceased alive on May 17, 1957 , and that death occurred at 1:45 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard Rigler		ADDRESS (Street, city or town, state) 1 W. Overlea Ave. Baltimore	
PHYSICIAN'S NAME (Type) Richard Rigler		DATE SIGNED 5-21-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 24, 1957	
22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassohn Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR DATE 5/24/57		24b. REGISTRAR'S SIGNATURE Mrs. A. L. Rignier	

4871

Item 12 Film G215 5-17-57 et

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. NAME OF DECEASED (Type or Print) SANTA BATTAGLIA			2. DATE OF DEATH 5/8/57		
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. Md. Co. B. FULL NAME OF (If not in hospital or institution, give street address or location) Towson, Md. 405 Hopkins Rd C. Length of stay in Baltimore Yrs. Mos. Days D. STREET ADDRESS (If rural, give location) 405 Hopkins Rd			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 405 Hopkins Rd D. STREET ADDRESS (If rural, give location) 405 Hopkins Rd		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 1868	9. AGE (In years last birthday) 89	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME Joseph Serio			14. MOTHER'S MAIDEN NAME Cefalu Italy		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT John F. Battaglia			ADDRESS 405 Hopkins Rd		
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO Arteriosclerotic Cardio-Vascular Disease			INTERVAL BETWEEN ONSET AND DEATH 3 yrs		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO CERTIFICATION APPROVED BY Karl F. [Signature] M.D. CHIEF OR ASST. MEDICAL EXAMINER					
19. 903.0 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT					
20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)			21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 12 1 56 m.			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
21F. HOW DID INJURY OCCUR? Fell to floor			22. I certify that (I) (this hospital) attended the deceased from December 1956 to May 8 1957 , that (I) (we) last saw the deceased alive on May 7 1957 , and that death occurred at 8:10 a.m. from the causes and on the date stated above.		
23A. SIGNATURE R.D. Lynn M.D.			23B. ADDRESS 11 C. Chase St		
23C. DATE SIGNED 5/19/57					
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial			24B. DATE May 11-1957		
24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery			24D. LOCATION (City, town, or county) (State) Old Frederick Rd. Balto Md.		
DATE RECEIVED BY LOCAL REGISTRAR 5/14/57			REGISTRAR'S SIGNATURE Mabel Gray		
25. FUNERAL DIRECTOR Wm. H. [Signature]			ADDRESS 712-14 E North Ave.		

THIS IS A PERMANENT RECORD. PLEASE TYPE OR WRITE PERMANENT BLACK OR BLUE-BLACK INK. DO NOT USE A BALL POINT PEN.

Every item of information should be fully supplied. Physicians: please write the causes of death clearly and legibly. HIS CERTIFICATE MUST BE FILED IN THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04846

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>30 White Thorneway</u>			
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>T.</u> Last <u>Batzer</u>				4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 23, 1887</u>	9. AGE (in years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Printer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		
13. FATHER'S NAME <u>Jos. A. Batzer</u>			14. MOTHER'S MAIDEN NAME <u>Julianna Bokel</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>J. Albert Batzer</u> Address <u>2706 Evergreen Avenue</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause lost. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-22-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, Inc.</u> ADDRESS <u>5305 Harford Rd.</u>			24a. REC'D BY REGISTRAR DATE <u>5/22/57</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hawley</u>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

MAY 22 1957

RECEIVED

4873

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3105 Du Bois Avenue</i>		d. STREET ADDRESS <i>1 3105 Du Bois Avenue</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mrs. Drucilla Irene Behr</i>		4. DATE OF DEATH <i>May 8th 1957</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 22, 1894</i>
9. AGE (In years last birthday) <i>62</i> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Saleslady</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Stewarts</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Harry Bowling</i>		14. MOTHER'S MAIDEN NAME <i>Florence Townsend</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-28-3758</i>	
17. INFORMANT <i>Mr. Russell Behr, 3105 Du Bois Ave.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma, Breast</i> <i>170X</i> DUE TO <i>metastases to Brain</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO (c) <i></i>			INTERVAL BETWEEN ONSET AND DEATH <i>17 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 1948</i> to <i>5/8</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>5/8</i> , 19 <i>57</i> , and that death occurred at <i>1040</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Nathan Janney</i>		ADDRESS (Street, city or town, state) <i>7101 Harford Rd Baltimore, Md.</i>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <i>7101 Harford Rd.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5/11/1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem Park</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>Dr. R. M. Bacon</i>		24b. REGISTRAR'S SIGNATURE <i>Dr. R. M. Bacon</i>	
DATE <i>5/14/57</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

MAY 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04848

4874

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Convalescent Home</u>				d. STREET ADDRESS <u>1847 Scharles</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Richard Adam Bell</u>		4. DATE OF DEATH <u>May 5, 1957</u>		5. SEX <u>Male</u>		6. COLOR OF RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 9, 1874</u>		9. AGE (In years, last birthday) <u>82 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mail Service</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Bell</u>				14. MOTHER'S MAIDEN NAME <u>Don't know</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Lewis E. Bell</u> Address <u>1847 Scharles</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure.</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>myocarditis chronic.</u> DUE TO (c) <u>myocardial hypertrophy</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day.</u> <u>5 yrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> <u>General arteriosclerosis.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no injury.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>noon</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>none</u>	
21. I certify that I attended the deceased from <u>9-25th</u> , 19 <u>26</u> , to <u>May 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 5</u> , 19 <u>57</u> , and that death occurred at <u>2:25 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>JAMES G. MARSTON</u>				ADDRESS (Street, city or town, state) <u>516 Cathedral Street</u>			
DATE SIGNED <u>5-6-57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 8, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>A.A. Bell</u> <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Howard Lewis</u> ADDRESS <u>1400 Scharles</u>				24a. REC'D BY REGISTRAR <u>May 6 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. Lewis</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN		17. SIGNATURE OF CLERGYMAN		18. SIGNATURE OF BURIAL OFFICIAL	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF CEMETERY		21. SIGNATURE OF INTERMENT		22. SIGNATURE OF CREMATION		23. SIGNATURE OF DONATION		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	

RECEIVED
 MAY 7 1957
 BUREAU V. 3

4842 CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>W. Va.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		LENGTH OF STAY (in this place) <u>2 mos</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Terra Alta</u>		<u>85X-3</u>	
TOWN <u>847-Mildred.</u>				TOWN <u>Terra Alta</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>847-Mildred. Ave</u>				STREET ADDRESS (If rural give location) <u>State-Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Opkie F. BENNETT</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>May 9 1957</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>July 8. 1875</u>	
9. AGE last birthday <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Terra Alta W. Va.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>At. Home</u>		11. BIRTHPLACE (State or foreign country): <u>Terra Alta W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>?</u>				14. MOTHER'S MAIDEN NAME: <u>Freeland.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>202-09-1557</u>		17. INFORMANT & ADDRESS: <u>FRANK B. FULTON-847 Mildred</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Dissecting aneurysm, abdominal aorta</u>						<u>16 hours</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Arteriosclerotic cardiovascular disease</u>						<u>7 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>204.0</u>						(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Leukemia, lymphatic, chronic</u>						<u>3 yrs</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1.2./23...</u> , <u>1952</u> , to <u>5/9...</u> , <u>1957</u> , that I last saw the deceased alive on <u>5/19</u> , <u>1957</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Louis Semenovoff</u>		ADDRESS <u>M. D. 1437 Furlow Ave Baltimore, Md</u>		DATE SIGNED <u>5/9/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/9/1957</u>		NAME OF CEMETERY OR CREMATORY <u>Terra Alta W. Va</u>		LOCATION (City, town, or county) (State) <u>W. Va</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3/10/57</u>		REGISTRAR'S SIGNATURE <u>Wm. Feltz</u>		24. FUNERAL DIRECTOR <u>W. B. Higbest</u>		ADDRESS <u>1300 Eutaw Pl</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

MAY 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04850

4875

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armcast Nursing Home 812 Regester Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sara Middle L. Last Bennett		4. DATE OF DEATH Month May Day 18 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1878
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Harford Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James K. Hamilton	
14. MOTHER'S MAIDEN NAME Matilda B. Grace		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Frank R. Hammond Address Upper Falls, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-Renal (c) Vascular Disease 11 yrs			INTERVAL BETWEEN ONSET AND DEATH 2 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 1, 1955 to May 18, 1957 that I last saw the deceased alive on May 12, 1957 and that death occurred at 4:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell, M.D.		ADDRESS (Street, city or town, state) 2501 York Rd Towson #4 Md	
PHYSICIAN'S NAME (Type) Charles F. O'Donnell, M.D.		DATE SIGNED 5/22/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 20, 1957	22c. NAME OF CEMETERY OR CREMATORY Salem Methodist	22d. LOCATION (City, town, or county) (State) Upper Falls, Balto. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lanahan Funeral Home		24a. REC'D BY REGISTRAR 7401 Belair Rd	24b. REGISTRAR'S SIGNATURE Mable Gray

MAY 22 1957

RECEIVED

4876

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 19 Walkern Road		d. STREET ADDRESS 19 Walkern Road	
3. NAME OF DECEASED (Type or print) First ANNA Middle JOSEPHINE Last BLAHA		4. DATE OF DEATH Month May Day 4th , Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 /16/1888
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 9 Days 19 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Checkoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frank Cizler		14. MOTHER'S MAIDEN NAME Barbara Pesic	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs George Lisson (Daughter)		Address Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO (b) H.C.V.D. DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
INTERVAL BETWEEN ONSET AND DEATH 45 mins ? yrs ? yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct , 19 55 , to 5/4 , 19 57 , that I last saw the deceased alive on 5/4 , 19 57 , and that death occurred at 3:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 434 Eastern Ave DATE SIGNED 5/4/57			
ACTUAL SIGNATURE J. Jay Blatty, M.D.		PHYSICIAN'S NAME (Type) J. Jay Blatty, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF May 4th, 57.	
22c. NAME OF CEMETERY OR CREMATORY St. Josephs		22d. LOCATION (City, town, or county) (State) Petersburg, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly		24. REGISTRAR'S SIGNATURE Edith Hurley	
ADDRESS 418 Eastern Blvd. Essex		DATE MAY 8 1957	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04852

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 7 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 22 Locust Drive		d. STREET ADDRESS 22 Locust Drive	
3. NAME OF DECEASED (Type or print) First William Middle E. Last Blake		4. DATE OF DEATH Month May Day 10 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1878
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Railway Express	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME -----Blake		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Margaret V. Blake, 22 Locust Drive		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. , 19 53 , to May 10 , 19 57 , that I last saw the deceased alive on May 6 , 19 57 , and that death occurred at 3:20P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Leo J. Gaver M.D. 1 Mallow Hill Ave., Baltimore, Md. 5/11/57 PHYSICIAN'S NAME (Type) LEO J. GAVER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 13/57	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke, 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE MAY 14 '57	
24b. REGISTRAR'S SIGNATURE Leo J. Gaver			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MAY 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4878

CERTIFICATE OF DEATH

05754

Reg. Dist. No. 44

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN lb 71 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH First Middle Last JAMES (NMI) BLANEY				5. SEX MALE 6. COLOR OR RACE COLORED 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 5/19/24 9. AGE (In years last birthday) 32 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Huckster				10b. KIND OF BUSINESS OR INDUSTRY Produce Business			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME TERRANCE BLANEY				14. MOTHER'S MAIDEN NAME VIOLA SMALLWOOD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII				16. SOCIAL SECURITY NO.			
17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANAPLASTIC CARCINOMA OF STOMACH WITH METASTASES 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 8 , 19 57 , to May 18 , 19 57 , that I last saw the deceased alive on May 18 , 19 57 , and that death occurred at 4:55 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Armen Bogosian M.D. Veterans Administration Hospital 5/19/57							
ACTUAL SIGNATURE Armen Bogosian M.D. Veterans Administration Hospital 5/19/57							
PHYSICIAN'S NAME (Type) ARMEN BOGOSIAN, M. D. FORT HOWARD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5-23-57			
22c. NAME OF CEMETERY OR CREMATORY Baltimore National				22d. LOCATION (City, town, or county) (State) Balto., Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE George G. Kelson				24a. REC'D BY REGISTRAR Dr. Dawson Parker			
ADDRESS 1348 N. Calhoun St.				DATE 5/30/57			

GEORGE G. KELSON FUNERAL DIRECTOR, 1348 N. Calhoun St, Balto., Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is oriented horizontally but contains text that is rotated 90 degrees clockwise.

BUREAU V. 2

MAY 20 1957

RECEIVED

INSTRUCTIONS

1 hours after death.

4 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04853

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		STATE <u>MD.</u> COUNTY <u>✓</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		LENGTH OF STAY (In this place) <u>18 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		TOWN <u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CATONRIDGE NURSING HOME</u>				STREET ADDRESS (If rural give location) <u>10 N WOLF E STREET</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>MARY ISABELL FISLER BLUME</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 15 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>OCT 28 1884</u>	9. AGE last birthday <u>72 yrs.</u>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>FROSEBURG MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WALTER SCHREIBER</u>				14. MOTHER'S MAIDEN NAME <u>MARY ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>WILLIAM R BLUME 10 N WOLF ST</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>420.1 myocardial infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>hypertensive arteriosclerotic cardiovascular disease</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>left hemiplegia</u>						<u>3 WKS</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr. 27, 1957</u> , to <u>May 15, 1957</u> , that I last saw the deceased alive on <u>May 14, 1957</u> , and that death occurred at <u>10:52</u> M, from the causes and on the date stated above.							
SIGNATURE <u>George A. Kump</u>				DATE SIGNED <u>May 15 1957</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				24. REC'D BY REGISTRAR			
DATE THEREOF <u>MAY 18 1957</u>				NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>			
REGISTRAR'S SIGNATURE <u>W. H. Beach</u>				LOCATION (City, town, or county) <u>RICHIE HCY MD</u>			
DATE <u>MAY 17 '57</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. B. B. 1800 E LOMBARD ST</u>			

CERTIFICATE OF DEATH

1. PLACE OF DEATH

2. SEX

3. AGE

4. RACE

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF CLERK

15. SIGNATURE OF JURY

16. SIGNATURE OF COURT

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF CONSTABLE

20. SIGNATURE OF TOWNSHIP CLERK

21. SIGNATURE OF TOWNSHIP SHERIFF

22. SIGNATURE OF TOWNSHIP CONSTABLE

23. SIGNATURE OF TOWNSHIP JURY

24. SIGNATURE OF TOWNSHIP COURT

25. SIGNATURE OF TOWNSHIP JUDGE

26. SIGNATURE OF TOWNSHIP SHERIFF

27. SIGNATURE OF TOWNSHIP CONSTABLE

28. SIGNATURE OF TOWNSHIP JURY

29. SIGNATURE OF TOWNSHIP COURT

30. SIGNATURE OF TOWNSHIP JUDGE

31. SIGNATURE OF TOWNSHIP SHERIFF

32. SIGNATURE OF TOWNSHIP CONSTABLE

33. SIGNATURE OF TOWNSHIP JURY

34. SIGNATURE OF TOWNSHIP COURT

35. SIGNATURE OF TOWNSHIP JUDGE

BUREAU V. 3

MAY 17 1957

RECEIVED

MASSACHUSETTS

4880

CERTIFICATE OF DEATH

04854

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 329 Harlem Lane, Catonsville 28, Md				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Theresa Middle Bogar Last Bogar				4. DATE OF DEATH Month May Day 2 Year 1957			
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 8, 1872	
9. AGE (In years last birthday) 84 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hungary	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Sipos		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-1013 INFORMANT Joseph Charnyei, 2619 Tulip Ave-Arbutus			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO pulmonary edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cardiac failure (c) myocardial degeneration arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 24 hrs. unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 21, 1957 to May 2, 1957 , that I last saw the deceased alive on 4/30 19 57 , and that death occurred at 6:42 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Cliff Ratliff M.D. 4605 Edmondson Ave				DATE SIGNED 5/4/57			
PHYSICIAN'S NAME (Type) CLIFF RATLIFF, JR.				4605 EDMONDSON AVE.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-6-57		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE David R. Martin ADDRESS 1902 Eutaw Place				24a. REC'D BY REGISTRAR DATE MAY 8 57		24b. REGISTRAR'S SIGNATURE Paul...	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES R. MARTIN		45		M		W		1912		BALTIMORE		MD		USA		USA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL HISTORY		PREVIOUS ILLNESS		TREATMENT		POST-MORTEM	
MAY 6 1957		BALTIMORE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		HYPERTENSION		DIABETES		SMOKING		ALCOHOL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF CHURCH OFFICIAL		SIGNATURE OF FUNERAL HOME		SIGNATURE OF CEMETERY	
JAMES R. MARTIN		JAMES R. MARTIN		JAMES R. MARTIN		JAMES R. MARTIN		JAMES R. MARTIN		JAMES R. MARTIN		JAMES R. MARTIN		JAMES R. MARTIN		JAMES R. MARTIN	

BUREAU V. 2

MAY 6 1957

RECEIVED

JAMES R. MARTIN

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4881

CERTIFICATE OF DEATH

048554

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore 19 MARYLAND</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>as</i> b. COUNTY <i>IN</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparrows Pt - 40 yrs</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>xo</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2912 Delmar Ave</i>			d. STREET ADDRESS <i>#1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Adam</i> First <i>a.</i> Middle <i>Boleski</i> Last			4. DATE OF DEATH <i>May</i> Month <i>2</i> Day <i>1957</i> Year		
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 24 1881</i>	9. AGE (In years last birthday) <i>75</i> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Barbary Worker Steel mill</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Joseph Boleskie</i>			14. MOTHER'S MAIDEN NAME <i>Mariana Barda</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>213-09-2161</i>		17. INFORMANT Address <i>Mike Lacy (as in #1)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Cardio Vascular disease</i> DUE TO (c) <i>12 yrs</i>					INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>331X</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3/12</i> , 19 <i>57</i> , to <i>May 2</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>May 1</i> , 19 <i>57</i> , and that death occurred at <i>530 N.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Reuben N. Tollin</i> M.D. <i>6908 N. Point Rd</i> PHYSICIAN'S NAME (Type) <i>LOUIS N. TOLLIN</i> <i>Balto 19 Md</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>5/6/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>SACRED HEART OF MARY GERMAN HILL RD DUNDALK</i>		22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward J. Meher</i>			24a. REC'D BY REGISTRAR <i>5/3/57</i>		24b. REGISTRAR'S SIGNATURE <i>Samuel L. Fairley</i>

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF INTERMENT	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	
SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
SIGNATURE OF DISTRICT ATTORNEY		SIGNATURE OF COUNTY CLERK	
SIGNATURE OF STATE CLERK		SIGNATURE OF STATE ARCHIVIST	
SIGNATURE OF STATE HISTORIAN		SIGNATURE OF STATE GEOLOGIST	
SIGNATURE OF STATE AGRICULTURIST		SIGNATURE OF STATE MINERALOGIST	
SIGNATURE OF STATE ZOOLOGIST		SIGNATURE OF STATE BOTANICIST	
SIGNATURE OF STATE ENTOMOLOGIST		SIGNATURE OF STATE METEOROLOGIST	
SIGNATURE OF STATE ASTRONOMER		SIGNATURE OF STATE PHYSICIST	
SIGNATURE OF STATE CHEMIST		SIGNATURE OF STATE ELECTRICIAN	
SIGNATURE OF STATE MECHANIC		SIGNATURE OF STATE ENGINEER	
SIGNATURE OF STATE ARCHITECT		SIGNATURE OF STATE LAND SURVEYOR	
SIGNATURE OF STATE JUDGE		SIGNATURE OF STATE CLERK	
SIGNATURE OF STATE ARCHIVIST		SIGNATURE OF STATE HISTORIAN	
SIGNATURE OF STATE GEOLOGIST		SIGNATURE OF STATE AGRICULTURIST	
SIGNATURE OF STATE ZOOLOGIST		SIGNATURE OF STATE BOTANICIST	
SIGNATURE OF STATE ENTOMOLOGIST		SIGNATURE OF STATE METEOROLOGIST	
SIGNATURE OF STATE ASTRONOMER		SIGNATURE OF STATE PHYSICIST	
SIGNATURE OF STATE CHEMIST		SIGNATURE OF STATE ELECTRICIAN	
SIGNATURE OF STATE MECHANIC		SIGNATURE OF STATE ENGINEER	
SIGNATURE OF STATE ARCHITECT		SIGNATURE OF STATE LAND SURVEYOR	

RECEIVED
MAY 6 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04856
49

4882

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 93 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 3320 RAVENWOOD AVENUE			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H Last BRAUL				4. DATE OF DEATH Month MAY Day 5 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 28, 1890	
9. AGE (In years last birthday) yrs. 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COLLECTOR		10b. KIND OF BUSINESS OR INDUSTRY COLLECTION AGENCY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM H. BRAUL, Sr.		14. MOTHER'S MAIDEN NAME DOROTHY HOMBURG			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-1		17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180 x METASTATIC HYPERNEPHROMA (LUNGS, ADRENALS AND PANCREAS) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERNEPHROMA, RIGHT KIDNEY DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.0 Arteriosclerotic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 5 YEARS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from FEB. 1 , 19 57 , to MAY 5 , 19 57 , that I was with the deceased at the time of death, and that death occurred at 11:20 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Md. DATE SIGNED 5/5/57							
ACTUAL SIGNATURE Armen Bogosian M.D.				DATE SIGNED 5/5/57			
PHYSICIAN'S NAME (Type) ARMEN BOGOSIAN, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/8/57		22c. NAME OF CEMETERY OR CREMATORY London Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm J Tickner & Sons, North & Pa. Avenues Baltimore, Md.				24a. REC'D BY REGISTRAR DATE 5/15/57		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED WILLIAM H. ERWIN</p>		<p>2. SEX M</p>		<p>3. AGE 35</p>		<p>4. DATE OF DEATH MAY 23, 1957</p>	
<p>5. PLACE OF DEATH 3320 KAYWOOD AVENUE BALTIMORE, MARYLAND</p>		<p>6. CAUSE OF DEATH HEART DISEASE</p>		<p>7. MANNER OF DEATH NATURAL</p>		<p>8. SIGNATURE OF PHYSICIAN [Signature]</p>	
<p>9. SIGNATURE OF REGISTRAR [Signature]</p>		<p>10. SIGNATURE OF WITNESS [Signature]</p>		<p>11. SIGNATURE OF WITNESS [Signature]</p>		<p>12. SIGNATURE OF WITNESS [Signature]</p>	

BUREAU V. S.

MAY 8 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

4883

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Pr. Georges</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> 1614.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		d. STREET ADDRESS <u>5001 Greenbelt Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>C.</u> Last <u>Bridges</u>		4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-10-85</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hiram Bridges</u>		14. MOTHER'S MAIDEN NAME <u>Helen Loetus</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>C. Mayo Attick</u>		Address <u>5004 Berwyn Park, College Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized and severe</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>0</u> Min. <u>19</u> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 14</u> , 19 <u>56</u> to <u>May 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 17, 1957</u> , 12 <u>PM</u> , and that death occurred at <u>5:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Spring Grove State Hosp</u> DATE SIGNED <u>5-17-57</u> ACTUAL SIGNATURE <u>William N. Karn, Jr.</u> M.D. PHYSICIAN'S NAME (Type) <u>William N. Karn, Jr., MD.</u> <u>Catonsville - 22, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-21-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 21 '57</u>	24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4884

CERTIFICATE OF DEATH

04858

Reg. Dist. No. 41

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point (19)</u>				c. LENGTH OF STAY IN 1b <u>33 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>907 H Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>OSCAR</u> Middle <u>BELL</u> Last <u>BRINKMAN</u>				4. DATE OF DEATH Month <u>May</u> Day <u>18th</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 15, 1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHECKER</u>		11. BIRTHPLACE (State or foreign country) <u>M.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY B. BRINKMAN</u>				14. MOTHER'S MAIDEN NAME <u>SARAH SEATON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-07-2882</u>			
17. INFORMANT <u>N.I. BRINKMAN</u>				Address <u>907 H St., Balto. 19</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Coronary Interction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>8-10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>July 14, 1953</u> , to <u>May 18, 1957</u> , that I last saw the deceased alive on <u>May 18, 1957</u> , and that death occurred at <u>11:47</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>914 D Street Balto. 19, Md.</u> DATE SIGNED							
ACTUAL SIGNATURE <u>David Owens</u> M.D.							
PHYSICIAN'S NAME (Type) <u>David Owens, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-21-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE</u>		22d. LOCATION (City, town, or county) (State) <u>DORSET, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter R. Ruddy, M.D.</u>				ADDRESS <u>Wm. R. Kelly</u>		24a. REC'D BY REGISTRAR DATE <u>5/21/57</u>	
24b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-10

NAME OF DECEASED <i>WILLIAM J. BRANNAN</i>		DATE OF BIRTH <i>1895</i>	PLACE OF BIRTH <i>NEW YORK</i>
OCCUPATION <i>SALES</i>		DATE OF DEATH <i>1957</i>	PLACE OF DEATH <i>NEW YORK</i>
CAUSE OF DEATH <i>HEART DISEASE</i>		MANNER OF DEATH <i>NATURAL</i>	
SIGNATURE OF DECEASED <i>WILLIAM J. BRANNAN</i>		SIGNATURE OF WITNESSES <i>JOHN J. BRANNAN</i>	
SIGNATURE OF PHYSICIAN <i>DR. J. J. BRANNAN</i>		SIGNATURE OF CLERK <i>JOHN J. BRANNAN</i>	

BUREAU A. 1

MAY 21 1957

RECEIVED

4885

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH Rosewood State Tr. School				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY Baltimore MARYLAND				a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401.4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood St. Training School				d. STREET ADDRESS 3433 Park Lawn Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Brinkley Middle Edward Last Brodka				4. DATE OF DEATH Month 5 Day 9 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/16/20		9. AGE (In years last birthday) 37 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Joseph Brodka				14. MOTHER'S MAIDEN NAME Anna Rau			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Parents and Rosewood Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral confluent broncho-pneumonia 491x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hydrocephalus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 752x							INTERVAL BETWEEN ONSET AND DEATH 5/2/57 2/16/20
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9/25/31 , 19____, to 5/9/57 , 19____, that I last saw the deceased alive on 5/9/57 , 19____, and that death occurred at 4:45 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Ellis S. Margolin M.D.							
PHYSICIAN'S NAME (Type) Rosewood State Training School							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 11-57	22c. NAME OF CEMETERY OR CREMATOR Jacksonwood Cemetery		22d. LOCATION (City, town or county) Taylor Baltimore Co. Md		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas A. Turk				24a. REC'D BY REGISTRAR DATE 5/13/57		24b. REGISTRAR'S SIGNATURE Mary Elsie	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED John Doe		SEX Male		AGE 45 Years		DATE OF BIRTH Jan 15, 1880		PLACE OF BIRTH Boston, Mass.	
FATHER'S NAME John Doe		MOTHER'S NAME Jane Doe		DATE OF DEATH May 10, 1937		PLACE OF DEATH Boston, Mass.		CAUSE OF DEATH Heart Disease	
OCCUPATION Clerk		EDUCATION High School		MARRIAGE Married		PREVIOUS ILLNESS None		HISTORY OF CASE Sudden	
DATE OF INTERMENT May 12, 1937		PLACE OF INTERMENT Catholic Cemetery		NAME OF MINISTER Rev. John Smith		NAME OF FUNERAL HOME Doe & Co.		SIGNATURE OF DECEASED None	
SIGNATURE OF PHYSICIAN Dr. John Smith		SIGNATURE OF CLERK John Doe		SIGNATURE OF WITNESS Jane Doe		SIGNATURE OF DECEASED None		SIGNATURE OF FUNERAL HOME Doe & Co.	

BUREAU V. 8

MAY 13 1937

RECEIVED

4886

CERTIFICATE OF DEATH

Reg. Dist. No.

39

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sparks Road		d. STREET ADDRESS Sparks Road	
3. NAME OF DECEASED (Type or print) Burnett DOUGLASS BURNETT		4. DATE OF DEATH MAY 16 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- General Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co.	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel O. Burnett		14. MOTHER'S MAIDEN NAME Eloise Douglass	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 10, 1957 to MAY 16, 1957 , that I last saw the deceased alive on MAY 16, 1957 , and that death occurred at 11:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE A. M. France M.D.		DATE SIGNED 5/17/57	
PHYSICIAN'S NAME (Type) A. M. FRANCE		PARKTON, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 18, 1957	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	22d. LOCATION (City, town, or county) (State) Pikesville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John Burns		24a. REC'D BY REGISTRAR DATE 5/20/57	
ADDRESS Towson, Md.		24b. REGISTRAR'S SIGNATURE Elizabeth Joranch	

CERTIFICATE OF DEATH

PLACE OF BIRTH		DATE OF BIRTH	
New York		April 6, 1917	
RACE		SEX	
White		Male	
EDUCATION		OCCUPATION	
High School		Clerical - General	
MARRIAGE		SPOUSE	
Never Married		None	
FAMILY RECORD		DATE OF DEATH	
Family Record		April 6, 1957	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Disease		Natural	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE	
April 6, 1957		April 6, 1957	

BUREAU V. 3

APR 20 1957

RECEIVED

4887

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OWINGS MILLS				c. LENGTH OF STAY IN 1b 3 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROSEWOOD STATE TRAINING SCHOOL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE SV01.4			
d. STREET ADDRESS 5219 LINDEN HEIGHTS AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANTHONY Middle JOSEPH Last BUSCEMI				4. DATE OF DEATH Month MAY Day 26 Year 1957			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-11-57	
9. AGE (In years last birthday) yrs. 4		IF UNDER 1 YEAR Months 4 Days 15		IF UNDER 24 HRS. Hours 15 Min. 4			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? AMERICA							
13. FATHER'S NAME FRANK JOSEPH BUSCEMI				14. MOTHER'S MAIDEN NAME LENORA PALUMBI			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 325.4		17. INFORMANT JOSEPH BUSCEMI Address 5219 LINDEN HEIGHTS AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rt. lower lobe pneumonia 490 X DUE TO mycoploid Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 36 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 325.4 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 5/25 , 19 57 , to 5/26 , 19 57 , that I last saw the deceased alive on 5/25 , 19 57 , and that death occurred at 12:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rosewood Lane Owings Mills, Md. DATE SIGNED 5/26/1957 ACTUAL SIGNATURE Ernest I. Decko M.D. PHYSICIAN'S NAME (Type) ERNEST I. DECCKO, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/27-1957		22c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER		22d. LOCATION (City, town, or county) (State) 4430 BELAIR RD.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank Dellapina				ADDRESS 3225 Highland		24a. REC'D BY REGISTRAR 27 1957	
24b. REGISTRAR'S SIGNATURE Mary Elinor							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2146252XV5

CERTIFICATE OF DEATH

PLACE OF BIRTH (State, County, City, Town, or Village)		PLACE OF DEATH (State, County, City, Town, or Village)	
DATE OF BIRTH (Month, Day, Year)		DATE OF DEATH (Month, Day, Year)	
SEX Male <input type="checkbox"/> Female <input type="checkbox"/>		RACE White <input type="checkbox"/> Negro <input type="checkbox"/> Other <input type="checkbox"/>	
OCCUPATION (If known)		CAUSE OF DEATH (If known)	
MANNER OF DEATH (If known)		MEDICAL HISTORY (If known)	
SIGNATURE OF DECEASED (If known)		SIGNATURE OF WITNESS (If known)	
SIGNATURE OF PHYSICIAN (If known)		SIGNATURE OF CORONER (If known)	
SIGNATURE OF JURY (If known)		SIGNATURE OF JUDGE (If known)	

BUREAU V. 2

MAY 27 1957

RECEIVED

4888
CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland c. LENGTH OF STAY IN 1b 8 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood St. Training School				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1611 Spruce Street 3401-4 d. STREET ADDRESS Baltimore 26, Maryland e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carolyn Middle Jean Last Butler				4. DATE OF DEATH Month 5/ Day 10 Year 1957			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/27/42	
9. AGE (In years last birthday) 14 1/2 yrs.		IF UNDER 1 YEAR Months 5 Days 10 Hours 19 Min.		IF UNDER 24 HRS. Months 5 Days 10 Hours 19 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) Maryland Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Junior Elias Butler		14. MOTHER'S MAIDEN NAME Ethel Augusta Turner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Parents and Rosewood Records		17. INFORMANT Parents and Rosewood Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock and acute hemorrhage from throat 510.1 DUE TO Trauma on the throat after T & A recovery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital heart disease due to Mongolism DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002x Pulmonary Tuberculosis - healed				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/3/49 , 19____, to 5/10/57 , 19____, that I last saw the deceased alive on 5/10/57 , 19____, and that death occurred at 5:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Viola B. Johns M.D.							
PHYSICIAN'S NAME (Type) Viola B. Johns, M.D.				Rosewood State Training School			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5-12-57		22c. NAME OF CEMETERY OR CREMATORY Nethkin Hill Cemetery		22d. LOCATION (City, town, or county) (State) Elk Garden, W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Inc. ADDRESS 12110 S Paul St Baltimore, Md				24a. REC'D BY REGISTRAR 5/13/57		24b. REGISTRAR'S SIGNATURE Mary Clini	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's signature, burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

MAY 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4889

CERTIFICATE OF DEATH

04863

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3yr 6mth 18dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Thomas</u> Last <u>Campbell</u>		4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1881</u>
9. AGE (In years last birthday) yrs. <u>75</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>iron worker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>217-01-8292</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized and severe</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 13</u> , 19 <u>57</u> , to <u>May 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 20</u> , 19 <u>57</u> , and that death occurred at <u>11:50a</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslers</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL</u> <u>5-20-57</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslers, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-24-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Rector</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook Inc. St. Paul's Rector</u>		24a. REC'D BY REGISTRAR <u>MAY 27 '57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4890

Items 11, 12 File G216 5-29-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

04864

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yr11mth27dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 2608 Rosewood Avenue	
3. NAME OF DECEASED (Type or print) First Harry Middle Caplan Last Caplan		4. DATE OF DEATH Month May Day 23 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH un/1887
9. AGE (In years lost birthday) 70? yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waiter		10b. KIND OF BUSINESS OR INDUSTRY unknown ??	
11. BIRTHPLACE (State or foreign country) ??		12. CITIZEN OF WHAT COUNTRY? ??	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 5 , 19 57 , to May 23 , 19 57 , that I last saw the deceased alive on May 23 , 19 57 , and that death occurred at 2:40aM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 5-23-57	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF May 24/57	22c. NAME OF CEMETERY OR CREMATORY Okech Shalom	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Vol. Linnex & Co. Inc. ADDRESS 1124-26 W. North		24a. REC'D BY REGISTRAR DATE MAY 27 '57	
24b. REGISTRAR'S SIGNATURE Overman			

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN J. JAMES		DATE OF DEATH MAY 27 1957	
AGE 45		SEX Male	
RACE White		MARRIAGE Married	
BIRTHPLACE Maryland		RESIDENCE Baltimore	
OCCUPATION Salesman		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		PLACE OF DEATH Home	
SIGNATURE OF PHYSICIAN J. J. James		SIGNATURE OF REGISTRAR J. J. James	
DATE OF SIGNATURE MAY 27 1957		DATE OF SIGNATURE MAY 27 1957	

BUREAU V. 2

MAY 27 1957

RECEIVED

4891

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 508 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 421 E. Biddle Street							
3. NAME OF DECEASED (Type or print) First JOHN Middle W. Last CARROLL				4. DATE OF DEATH Month May Day 13 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 18, 1895	
9. AGE (In years birthday) yrs. 61		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) St. Marys County	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Francis M. Carroll				14. MOTHER'S MAIDEN NAME Laura Mattingly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 577-09-8205		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL 491x NEUR SPINAL CORD LESION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 1 1/2 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 357x							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from December 22, 1955 , to May 13, 1957 XXXXXX and that death occurred at 2:10A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED CHIHEN WEI LAN, M.D. VAH, FORT HOWARD, MARYLAND 5/13/57 ACTUAL SIGNATURE Chien Wei Lan PHYSICIAN'S NAME (Type) CHIHEN WEI LAN, M.D. VAH, FORT HOWARD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-16-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc. ADDRESS 6009 Harford Rd., Balto. 14, Md.				24a. REC'D BY REGISTRAR DATE 5/16/57		24b. REGISTRAR'S SIGNATURE Dr. Dawson L. Fisher	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		John H. Jones	
Sex		Male	
Date of Birth		November 10, 1892	
Place of Birth		Maryland	
Usual Residence		Baltimore, Maryland	
Cause of Death		Heart Disease	
Date of Death		November 15, 1957	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

BUREAU V. 3

NOV 17 1957

RECEIVED

4892

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Minnesota b. COUNTY -----	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		c. LENGTH OF STAY IN 1b 9 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4 Cavan Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle A. Last Chapman		4. DATE OF DEATH Month 5-16-57 Day 19 Year 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-29-1880
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		9b. KIND OF BUSINESS OR INDUSTRY home	9c. AGE (In years last birthday) 76 yrs.
10a. BIRTHPLACE (State or foreign country) West Virginia		10b. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. FATHER'S NAME Marion Casey		12. MOTHER'S MAIDEN NAME Martha Gilbert	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		14. SOCIAL SECURITY NO. none	
15. INFORMANT Mrs. Cyrus Granger, 4 Cavan Dr., Towson 4, Md.		16. ADDRESS Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac Failure DUE TO (c) Arteriosclerosis is generalized 15 yrs.		INTERVAL BETWEEN ONSET AND DEATH 6 hours 24 hours 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 15, 1957 , to May 16, 1957 that I last saw the deceased alive on May 16, 1957 , and that death occurred at 3:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lutherville, Md. DATE SIGNED ACTUAL SIGNATURE George T. Gilmore M.D. PHYSICIAN'S NAME (Type) G. T. GILMORE, MD LUTHERVILLE, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-21-57	22c. NAME OF CEMETERY OR CREMATORY Hillside Cemetery	22d. LOCATION (City, town, or county) (State) Minneapolis, Minn.
23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks		24a. REC'D BY REGISTRAR May 17, 1957	24b. REGISTRAR'S SIGNATURE Mabel C. Gray

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		65		1892		BALTIMORE		MD		USA			
OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
RETIRED		HIGH SCHOOL		MARRIED		1957		BALTIMORE		MD		USA			
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
HEART DISEASE		NATURAL		1		1957		BALTIMORE		MD		USA			
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04867

4893

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 2 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS Box 696 Route 1, Riverside Drive	
3. NAME OF DECEASED (Type or print) First HARRY Middle CICCOTELLI Last CICCOTELLI		4. DATE OF DEATH Month May Day 14 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1894
9. AGE (In years last birthday) yrs. 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Errico Ciccotelli		14. MOTHER'S MAIDEN NAME Beatrice Santilli	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 164-14-6484	
17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 DAYS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from May 12 , 19 57 , to May 14 , 19 57 , and that death occurred at 6:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James J. Nolan M.D. VAH, FORT HOWARD, MARYLAND 5/14/57			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) JAMES J. NOLAN, Assistant Chief, Medical Service	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-17-57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.		24a. REC'D BY REGISTRAR DATE 5/16/57	
ADDRESS 6009 Harford Rd., Balto, Md.		24b. REGISTRAR'S SIGNATURE Dr. Dawson Farber	

CERTIFICATE OF DEATH

1958

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 15, 1913		New York City		Natural		Heart Disease		Home		Jan 10, 1958		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	
Box 800 House 1 Riverside Drive																							
Race		White		Married		Single		Widow		Divorced		Never Married											
Occupation		Teacher		Homemaker		Student		Unemployed		Retired													
Education		High School		College		Graduate School																	
Religion		Catholic		Protestant		Jewish		Muslim		Other													
Usual Residence		New York City		New York City		New York City		New York City		New York City													
Date of Death		Jan 10, 1958		Jan 10, 1958		Jan 10, 1958		Jan 10, 1958		Jan 10, 1958													
Time of Death		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM													
Signature of Physician		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.													
Signature of Registrar		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.													

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MAY 17 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04868

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gray Manor		c. LENGTH OF STAY IN 1b 4 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Gray Manor				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2706 North Point Road				d. STREET ADDRESS 2706 North Point Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Barbara Middle Cizler Last Cizler				4. DATE OF DEATH Month May Day 3 Year 1957				
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1880		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 76 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? Czech.		
13. FATHER'S NAME Frank Cizler				14. MOTHER'S MAIDEN NAME Barbara Pesic				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address John Cizler, 2706 North Point Rd.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 2 hours		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE Jack E Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Jack E Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/3/57		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cem.		22d. LOCATION (City, town, or county) _____ (State) _____ Petersburg, Va.		
23. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.				24a. REC'D BY REGISTRAR MAY 6 1957				24b. REGISTRAR'S SIGNATURE Edith Burley

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04869

4895

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 8yr6mth5d6s	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 vol. 4		d. STREET ADDRESS 2825 Parkwood Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ellis Middle Last Cohen		4. DATE OF DEATH Month May Day 3 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1879
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russia	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstructive jaundice DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, head of pancreas DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 13 , 19 57 , to May 3 , 19 57 , that I last saw the deceased alive on May 3 , 19 57 , and that death occurred at 3:45 a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 5-3-57			
ACTUAL SIGNATURE Stella Wachslar M.D.		PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-5-57	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Kwin		24a. REC'D BY REGISTRAR DATE MAY 6 57	
ADDRESS 2100 Gutter Pl		24b. REGISTRAR'S SIGNATURE Rebecca	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4896
CERTIFICATE OF DEATH

Reg. Dist. No.

04870

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harf.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood 12X212	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Codd Convalescent Home		d. STREET ADDRESS Route 40, Edgewood	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN THOMAS CROWE First Middle Last		4. DATE OF DEATH May 16, 1957 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1878
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Steamfitter		10b. KIND OF BUSINESS OR INDUSTRY Plumber	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Crowe		14. MOTHER'S MAIDEN NAME Mary Lanning	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family records		Address	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Decompensative Cardio Vascular Disease 422.1 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-15 , 19 57 , to 5-16 , 19 57 , that I last saw the deceased alive on 5-16 , 19 57 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Laurence C. Post		ADDRESS (Street, city or town, state) 6805 York Rd Baltimore Md.	
DATE SIGNED 5-17-57			
PHYSICIAN'S NAME (Type) LAURENCE C. Post			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 18, 1957	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Wilkesbarre, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons		ADDRESS Towson, Maryland	
24a. REC'D BY REGISTRAR May 18, 1957		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

MAY 21 1957

RECEIVED

4897

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5904 Harford Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Catherine Middle Dailey Last Dailey		4. DATE OF DEATH Month May Day 20 Year 19 57	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1899
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Kuester		14. MOTHER'S MAIDEN NAME Matilda	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs George Lindner		Address Catonsville 28, 5904 Harford Ave Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Uterus 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH About 10 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December, 1956 , to May 20, 1957 , that I last saw the deceased alive on May 20, 1957 , and that death occurred at 9:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmundson		ADDRESS (Street, city or town, state) 4508 Edmondson Village	
PHYSICIAN'S NAME (Type) D. C. MacLaughlin, M.D.		DATE SIGNED 5/24/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 23/57	
22c. NAME OF CEMETERY OR CREMATORY London Park Cemetery		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Edmondson Ave		24a. REC'D BY REGISTRAR MAY 22 '57	
24b. REGISTRAR'S SIGNATURE W. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		SEX Male	
DATE OF BIRTH 10-10-1895		AGE 60	
PLACE OF BIRTH Baltimore, Md.		RACE White	
OCCUPATION Laborer		MARITAL STATUS Married	
PLACE OF DEATH 3200 Madison Ave.		DATE OF DEATH 11-10-1957	
TIME OF DEATH 11:00 AM		CAUSE OF DEATH Myocardial Infarction	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

BUREAU V. 4

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

41

4843

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u> 3401.4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BLDG. PROPERTY STANBURY RD + MERRITT BLVD.</u>				d. STREET ADDRESS <u>2316 W. Lamvale St</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Chester A DAVIS</u>				4. DATE OF DEATH Month Day Year <u>MAY 29 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-10-97</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister & Construction worker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>S.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		
13. FATHER'S NAME <u>Frank Davis</u>			14. MOTHER'S MAIDEN NAME <u>Phyllis Drummond</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mama C. Davis</u> Address <u>2316 W Lamvale St</u>		
18. CAUSE OF DEATH [Enter only one cause for line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing Injury - Chest</u> 910.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Engaged in open pit excavation for sewer line. Patient was buried in falling dirt and rock.</u>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>STREET</u>		20f. (City or town) (County) (State) <u>DUNDALK, BALTO. md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack Collins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JACK COLLINS, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-3-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arden Men Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel W. Sullivan Jr - Balto</u>				24a. REC'D BY REGISTRAR <u>5/31/57</u>		24b. REGISTRAR'S SIGNATURE <u>Thm. Kelly</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

RECEIVED
MAY 31 1957
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04872

Reg. Dist. No.

4844

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> c. LENGTH OF STAY IN 1b <u>X2 Dundalk</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8221 Watersedge Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> d. STREET ADDRESS <u>8221 Watersedge Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Emma Virginia Bell</u> First Middle Last				4. DATE OF DEATH <u>May 26</u> 19 <u>57</u> Month Day Year			
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 17, 1885</u> Yrs.		9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>William Evers</u>				14. MOTHER'S MAIDEN NAME <u>Jennie L. Cox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>William Meyer</u> Address <u>8221 Watersedge Rd. Dundalk.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>H-S-E-V-DISEASE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M. B. Davis</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. B. Davis M.D.</u>				DATE SIGNED <u>5/27/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-29-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Ph.</u>		22d. LOCATION (City, town, or county) <u>Baltimore md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u> ADDRESS <u>4107 Wilkes Ave.</u>				24a. REC'D BY REGISTRAR <u>M. J. Kelly</u>		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEWLAND STATE DEPARTMENT OF HEALTH - BIRMINGHAM 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAY 29 1957
BUREAU V. S.

4898

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Texas				c. LENGTH OF STAY IN lb 20 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month May Day 28 Year 19 57				d. STREET ADDRESS Church Lane			
3. NAME OF DECEASED (Type or print) First MICHAEL Middle DeLUCIA Last DeLUCIA				4. DATE OF DEATH Month May Day 28 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-4-1895	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 61 Hours 61 Min. 61		IF UNDER 24 HRS. Months 61 Days 61 Hours 61 Min. 61			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY quarry		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Dominic DeLucia				14. MOTHER'S MAIDEN NAME Mary ???? ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 218-07-8064			
17. INFORMANT Mrs. Mary DeLucia, Cockeysville, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) 422.1 (a), stating the underlying cause lost. DUE TO (c) 422.1							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Paul F. Guerin				DATE SIGNED 5/29/57			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-1-57		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's		22d. LOCATION (City, town, or county) (State) Cockeysville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service				24a. REC'D BY REGISTRAR 2. Scott Brooks			
24b. REGISTRAR'S SIGNATURE Wm. J. Chilcote				24c. ADDRESS 622 York Rd. Towson 4, Md.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAY 31 1957
BUREAU V. R.

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		35		12-15-21	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Boston, Mass.		Boston, Mass.		Heart Disease		Natural	
Occupation		Education		Marital Status		Social History	
Teacher		High School		Married		No	
Date of Death		Time of Death		Place of Death		Physician	
May 30, 1957		10:00 AM		Home		Dr. J. Smith	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Clerk	
[Signature]		[Signature]		[Signature]		[Signature]	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **411**

04874

4845

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK			c. LENGTH OF STAY IN 1b 30 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11 TOWNSHIP				d. STREET ADDRESS 11 Township Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ERNEST Middle HENRY Last DIEKMANN				4. DATE OF DEATH Month May Day 21 Year 19 57				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 18, 1891		
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ROLLER			10b. KIND OF BUSINESS OR INDUSTRY STEEL MFR.		11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANTON				14. MOTHER'S MAIDEN NAME HELENA SCHLOESSER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-10-3188		17. INFORMANT Blanch B. Diekmann - Son Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CranioCerebral Injury 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down stairs.					
20c. TIME OF INJURY Month, Day, Year Hour 2:00 P.M. 5/20 1957		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Dundalk Baltimore Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE Paul F. Guerin		EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/21/57		
				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/23/1957		22c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM.		22d. LOCATION (City, town, or county) (State) DORSEY, MD.		
23. FUNERAL DIRECTOR'S SIGNATURE Wm. M. Tully				ADDRESS Dundalk, Md.		24a. REC'D BY REGISTRAR Wm. M. Tully		
						24b. REGISTRAR'S SIGNATURE Wm. M. Tully		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
J. J. J. J. J.		M		30 YRS	
Date of Death		Place of Death		Cause of Death	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
Time of Death		Place of Burial		Signature of Medical Examiner	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
Signature of Coroner		Signature of Registrar		Signature of Medical Examiner	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	

BUREAU V. 21

1057

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4899

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY in 1b 28 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V01.4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2926 Harford Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARENCE		Middle (Reese) R.		Last DIETRICH		4. DATE OF DEATH Month May	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 10, 1896	
9. AGE (In years last birthday) 60		IF UNDER 1 YEAR Months 28		IF UNDER 24 HRS. Days 19		Hours 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME (Clarence) Adam C. Dietrich				14. MOTHER'S MAIDEN NAME Margaretta Reese			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT 218-26-0572		Address Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE 237X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) INFILTRATING TUMOR, PARIETAL FRONTAL BRAIN DUE TO (c) UNKNOWN						INTERVAL BETWEEN ONSET AND DEATH 12 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation - Craniotomy - 5/26/57						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 30 , 19 57 , to May 28 , 19 57 , that I last saw the deceased XXXXXX , and that death occurred at 8:55A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Milton Ginsberg M.D. VAH, FORT HOWARD, MARYLAND 5/28/57							
ACTUAL SIGNATURE Milton Ginsberg PHYSICIAN'S NAME (Type) MILTON GINSBERG, M.D., Acting Chief, Surgical Service							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/31/57		22c. NAME OF CEMETERY OR CREMATORY St. Johns Waverly Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner and Sons, Inc. North & Penna. Ave. Baltimore, Md.				24a. REC'D BY REGISTRAR DATE 5/29/57		24b. REGISTRAR'S SIGNATURE Harold L. Farley	

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. S.

MAY 31 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04876

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wiltondale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Wiltondale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>601 Hastings Rd</u>		d. STREET ADDRESS <u>1601 Hastings Rd</u>	
3. NAME OF DECEASED (Type or print) <u>LOURSA D DINSMORE</u>		4. DATE OF DEATH <u>May 4 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 22 1864</u>
9. AGE (In years last birthday) <u>92</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Henry Duker</u>	
14. MOTHER'S MAIDEN NAME <u>Rose Drechsler</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>585x</u>		17. INFORMANT <u>Mrs G Lochman Croll</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cholesterol</u> DUE TO (c) <u>cholesterol</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>585x</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1952</u> to <u>May 4, 1957</u> , that I last saw the deceased alive on <u>May 1, 1957</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Milton B. Kress</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>MILTON B. KRESS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>May 7 1957</u>	<u>LODDON PARK</u>	<u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins</u> ADDRESS <u>4905 York Rd</u>		24a. REC'D BY REGISTRAR <u>5/6/57</u>	24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>

RECEIVED
MAY 2 1964

4901

CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> <u>1614.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State</u>				d. STREET ADDRESS <u>9021 50th Place</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Albert</u> Last <u>Doyle</u>				4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/23/89</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Yeast Plant</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Doyle</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Reed</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-05-0862</u>		17. INFORMANT Address <u>Hospital Records, Mt. Wilson State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis Pulmonary</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Far Advanced Pulmonary Tuberculosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>5/13</u> , 19 <u>57</u> , to <u>5/24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/24</u> , 19 <u>57</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Mt. Wilson, Maryland</u> DATE SIGNED							
ACTUAL SIGNATURE <u>William Newcomer</u> M.D. <u>Mt. Wilson, Maryland</u>							
PHYSICIAN'S NAME (Type) <u>WILLIAM NEWCOMER, M. D., Superintendent</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Johns Cemetery</u>		22d. LOCATION (City, town, or county) <u>Beltsville, Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 29 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dorothy Jewell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MAY 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04878

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Glyndon				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Glyndon X 2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mantau Mill Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DIANA Middle ESTHER Last EDGAR				4. DATE OF DEATH Month May Day 18 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 27, 1887	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Scotland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Edgar				14. MOTHER'S MAIDEN NAME Helen Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-16-3885		17. INFORMANT Address Mrs. Robert Scott, Baltimore, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
INTERVAL BETWEEN ONSET AND DEATH 30 min.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. none p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D. D. Caples, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5-21-57		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	
				22d. LOCATION (City, town, or county) Pikesville, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons, Balto. 17, Md.				24a. REC'D BY REGISTRAR DATE 5/22/57		24b. REGISTRAR'S SIGNATURE Mary Clin	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAY 22 1957
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4903

CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jones Creek		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jones Creek x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7403 Linwood Avenue		d. STREET ADDRESS 7403 Linwood Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ruby Middle Elliott Last Elliott		4. DATE OF DEATH Month May Day 6 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1889
9. AGE (In years last birthday) yrs. 67		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Wilmington, Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Forrest		14. MOTHER'S MAIDEN NAME Agnes Campbell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Fred H. Elliott		Address 200 N. Branch Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Coronary Insufficiency Conditions, if any, which gave rise to immediate case (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 4 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 5, 1953 to May 6, 1957 , that I last saw the deceased alive on May 6, 1957 , and that death occurred at 6:04 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James T. Means		ADDRESS (Street, city or town, state) 520 D. St. Balto 19 Md	
PHYSICIAN'S NAME (Type) James T. Means		DATE SIGNED 5/6/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 9, 1957	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Eastern Ave., Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc		ADDRESS 6009 Harford Rd	
24a. REC'D BY REGISTRAR 5/8/57		24b. REGISTRAR'S SIGNATURE Thos P. Kelly	

BUREAU V. S.

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05756

4904

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 512 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS Forest Pk. Ave. & Windson Gate House, Kernan Hospital			
3. NAME OF DECEASED (Type or print) First JOHN Middle R. Last ELLY				4. DATE OF DEATH Month May Day 31 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 11, 1892	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer				10b. KIND OF BUSINESS OR INDUSTRY Private Practice			
11. BIRTHPLACE (State or foreign country) Louisa County, Virginia				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles C. Elly				14. MOTHER'S MAIDEN NAME Lillie Kuper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. None			
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS, RIGHT MIDDLE CEREBRAL ARTERY 332X DUE TO ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 YEARS 6 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1. Hypertensive Cardiovascular Disease 2. Infarction of Myocardium due to Arteriosclerotic Coronary Thrombosis, old.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 420.1				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from December 12, 1955 , to May 31, 1957 , and that death occurred at 2:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Irving Freeman M.D. VAH, FORT HOWARD, MARYLAND 5/31/57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 3/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Edmondson Ave.				24a. REC'D BY REGISTRAR 1957 24b. REGISTRAR'S SIGNATURE Lawson L. Larkins			

CERTIFICATE OF DEATH

NAME OF DECEASED: John Doe
 SEX: Male AGE: 45 YEARS
 DATE OF BIRTH: Jan 15, 1905
 PLACE OF BIRTH: St. Louis, Mo.
 OCCUPATION: Teacher
 MARITAL STATUS: Married
 NAME OF SPOUSE: Jane Doe
 PLACE OF DEATH: Home
 DATE OF DEATH: June 10, 1957
 TIME OF DEATH: 10:30 AM
 CAUSE OF DEATH: Heart Disease
 MEDICAL HISTORY: None
 SIGNATURE OF PHYSICIAN: [Signature]
 SIGNATURE OF WITNESS: [Signature]
 SIGNATURE OF DECEASED: [Signature]

BUREAU V. 3

JUN 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04880

4995

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 ESSEX	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 144 RIVERSIDE RD.		d. STREET ADDRESS 144 RIVERSIDE RD.	
3. NAME OF DECEASED (Type or print) First EARL Middle F Last ENDT		4. DATE OF DEATH Month MAY Day 23 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 27-1894
9. AGE (In years lost birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY PENN. R. R.	
11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME PETER ENDT		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT VIRGINIA ENDT		Address SAME AS ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure, leftsided, backward 022X DUE TO Moortic aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Syphilis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tuberc dorsalis.		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 years more than 27 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-15 , 19 56 , to 5-21 , 19 57 , that I last saw the deceased alive on 5-21 , 19 57 , and that death occurred at 11:45 PM , from the causes and on the date stated above. on 5-23-57 ADDRESS (Street, city or town, state) 5725/57th Ind. DATE SIGNED ACTUAL SIGNATURE Eugene C. Baumann M.D. 413 Eastern Ave. Essex 21, Ind. PHYSICIAN'S NAME (Type) Eugene C. Baumann			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/27/57	
22c. NAME OF CEMETERY OR CREMATORY BELAIR MEM. GARDEN		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly		ADDRESS 418 Eastern Ave. Baltimore 21 Ind.	
24a. REC'D BY REGISTRAR MAY 29 1957		24b. REGISTRAR'S SIGNATURE Edith Hurley	

BUREAU V. S.

MAY 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4846

Item 11, Film G216 5-29-57 et

CERTIFICATE OF DEATH

04881

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				c. LENGTH OF STAY IN 1b <u>56 years</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Dundalk 22</u>				d. STREET ADDRESS <u>49 Admiral Blvd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7008 Morington Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JULIANA</u> Middle <u>SALECELY</u> Last <u>ERJAUTZ</u>				4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/17/1870</u>	9. AGE (In years last birthday) yrs. <u>87</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>family home</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Erbin Salecely</u>				14. MOTHER'S MAIDEN NAME <u>Juliana Salecely</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>F.L. KOENIG</u> Address <u>418 E. 28th St. Balto.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>A-S-C-V-DISEASE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>10yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Cholecystitis 585X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Dundalk 22 Md.</u>	
21. I certify that I attended the deceased from <u>April 29, 1957</u> to <u>May 18, 1957</u> that I last saw the deceased alive on <u>May 17, 1957</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M.B. Davis M.D.</u> M.D. <u>6800 MURKIN RD BALTO MD</u>				DATE SIGNED <u>5/20/57</u>			
PHYSICIAN'S NAME (Type) <u>M.B. Davis M.D.</u>		<u>Dundalk 22 Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Jesus</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore 22 Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter George Bradley</u>				ADDRESS <u>Dundalk 22, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 5/21/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. M. Kelly, Jr.</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04882

Reg. Dist. No. 38

4996

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>55 Towson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>622 Overbrook Road</i>		d. STREET ADDRESS <i>622 Overbrook Road</i>	
3. NAME OF DECEASED (Type or print) <i>Mr. Leroy Esposito</i>		4. DATE OF DEATH <i>May 13 1957</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 2, 1906</i>
9. AGE (In years last birthday) <i>51</i> yrs.		IF UNDER 1 YEAR: Months <i>51</i> Days <i>13</i> Hours <i>19</i> Min. <i>57</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Anthony Esposito</i>		14. MOTHER'S MAIDEN NAME <i>Wilhelmina Rocckel</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>213-03-7065</i>	
17. INFORMANT <i>Mrs. Dorothy Esposito, 622 Overbrook Rd</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the Pancreas with</i> <i>157X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>metastases</i> DUE TO (c) <i>abdominal exploratory operation</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 year 3/11/57</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 43</i> , 19 <i>57</i> , to <i>May 13</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>May 13</i> , 19 <i>57</i> , and that death occurred at <i>7:40 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ed Alessi</i>		DATE SIGNED <i>5/13/57</i>	
PHYSICIAN'S NAME (Type) <i>Dr. Edward J. Alessi</i>		M.D. <i>6217 Harford Road</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5/16/1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Louisa PARK</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>DATE 5/14/57</i>		24b. REGISTRAR'S SIGNATURE <i>Mabel Joy</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4997

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Fredrick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland		c. LENGTH OF STAY IN 1b 38 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Tr. School		d. STREET ADDRESS Route # 1	
3. NAME OF DECEASED (Type or print) First Melvin Middle Elwood Last Etzler		4. DATE OF DEATH Month 5 Day 10 Year 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/18/11
9. AGE (In years last birthday) 46		IF UNDER 1 YEAR: Months 5 Days 10 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles P. Etzler		14. MOTHER'S MAIDEN NAME Rosa Mary Welty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Rosewood Records	
17. INFORMANT Rosewood Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia DUE TO (c) Chronic Cysto-pyelo-nephritis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 325.4 Mongoloid Idiocy		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/1/19 , 19 57 , that I last saw the deceased alive on 5/10/57 , 19 57 , and that death occurred at 12:20 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Rich. L. Lutz (Pathologist) M.D.		Rosewood State Training School	
PHYSICIAN'S NAME (Type)		Rosewood State Training School	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	5/13/57	Rosewood Cemetery	Owings Mills Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Lutz - Ann Rustenburg		24a. REC'D BY REGISTRAR 5/13/57	
ADDRESS		24b. REGISTRAR'S SIGNATURE Mary B. Shive	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4853

CERTIFICATE OF DEATH

04884

Reg. Dist. No. 42

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus 51	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1227 Stevens Avenue		d. STREET ADDRESS 1227 Stevens Avenue 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas John Middle Fahey Last		4. DATE OF DEATH Month May Day 14 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1881
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Postal Clerk		10b. KIND OF BUSINESS OR INDUSTRY Post Office	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Fahey		14. MOTHER'S MAIDEN NAME Rose Connelly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Jessie C. Fahey		Address 1227 Stevens Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May , 19 54 , to May 14 , 19 57 , that I last saw the deceased alive on August , 19 56 , and that death occurred at 8 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert J. Levickas		ADDRESS (Street, city or town, state) 5305 East Drive	
PHYSICIAN'S NAME (Type) Herbert J. Levickas		DATE/SIGNED 5/16/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-17-57	22c. NAME OF CEMETERY OR CREMATORY New Cathedral
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	
24a. REC'D BY REGISTRAR 5/17/57		24b. REGISTRAR'S SIGNATURE Dr. J. S. Ruffin	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1853

NAME OF DECEASED JAMES H. HARRIS		SEX Male	
DATE OF BIRTH 1885		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Laborer		CAUSE OF DEATH Heart Disease	
DATE OF DEATH May 17, 1957		PLACE OF DEATH Home	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

BUREAU V. S.

MAY 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4908

CERTIFICATE OF DEATH

04885
27

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore 3Y01-4			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor				d. STREET ADDRESS Rd. Roland Pk. Apts. - 6 Upland			
3. NAME OF DECEASED (Type or print) First Edna Middle S. Last Farber				4. DATE OF DEATH Month May Day 6 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1886		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Seal				14. MOTHER'S MAIDEN NAME Johanna Roth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-07-8746B		17. INFORMANT Mr. Eugene McInnis - 101 W. Monument St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerotic Cardio Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July 10, 1951 to 6 May, 1957 , that I last saw the deceased alive on 6 May, 1957 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE William J. Pickens M.D.				ADDRESS (Street, city or town, state) 5006 Upland Ave Baltimore			
PHYSICIAN'S NAME (Type)				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/8/57		22c. NAME OF CEMETERY OR CREMATORY Lorraine Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickens & Sons - Balt.				24a. REC'D BY REGISTRAR DATE 5/8/57		24b. REGISTRAR'S SIGNATURE Dr. A. H. Hedrick	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU

MAY 9 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

04886
33

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland c. LENGTH OF STAY IN 1b 48 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 1318 35th Street, N.W., Wash, D e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leo Middle Fields Last Fields		4. DATE OF DEATH Month 5 Day 23 Year 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/91
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 23 Hours 19 Min. 57	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		Maryland	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Catherine Fields	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Rosewood Tr. School - Owings Mills, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary insufficiency DUE TO (c) Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002x Idiocy, old pulmonary tuberculosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/27/09 , 19____, to 5/23/57 , 19____, that I last saw the deceased alive on 5/23/57 , 19____, and that death occurred at 5:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 700 Fleet Street, Bk/w. 2 DATE SIGNED			
ACTUAL SIGNATURE Rich. Pinkney (Physician)			
PHYSICIAN'S NAME (Type) Rich. Lindenberg 5/24/57 Rosewood State Training School			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	May 27-57	Rosewood cemetery	Owings Mills Md
23. FUNERAL DIRECTOR'S SIGNATURE J. A. Erlingston		24a. REC'D BY REGISTRAR DATE 5-27-57	
ADDRESS Presbyterian		24b. REGISTRAR'S SIGNATURE Mary B. Eline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4910

CERTIFICATE OF DEATH

048878

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Stevenson P.O.</u>		c. LENGTH OF STAY IN 1b <u>6 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anton Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>NMI</u> Last <u>Fink Sr.</u>		4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>30 aug 1876</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>secretarial</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Louis Fink</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Spealman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>miss Fred Fink</u>	
17. INFORMANT <u>Stevenson P.O. Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>few years</u> INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> to <u>30 May</u> , 1957, that I last saw the deceased alive on <u>30 May</u> , 1957, and that death occurred at <u>5:20</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul H Royse</u> M.D.		DATE SIGNED <u>30 May 57</u>	
PHYSICIAN'S NAME (Type) <u>Paul H Royse MD</u>		<u>Pikesville 8 rd.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>June 1/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart Mounier</u>		ADDRESS <u>1000 North - Balt</u>	
24a. REC'D BY REGISTRAR <u>JUN 3 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mark Gay</u>	

BUREAU A. 3

JUN 3 1957

RECEIVED

4911

CERTIFICATE OF DEATH

Reg. Dist. No. 38

THIS IS A PERMANENT RECORD. PLEASE TYPE WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information must be carefully supplied. Physicians: please write the causes of death clearly and legibly. This certificate must be filed with the Bureau of Vital Records within THREE (3) DAYS AFTER

1. NAME OF DECEASED (Type or Print) <i>Mr. William J. Frank</i>			2. DATE OF DEATH <i>May 4, 1957</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore County</i>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence) A. STATE <i>Maryland</i> B. COUNTY <i>BALTO.</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>4246 Cardwell Avenue</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>4246 Cardwell Avenue</i>		
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>Feb. 5, 1880</i>	9. AGE (In years last birthday) <i>77</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Caretaker and Farmer</i>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <i>Chestnut Ridge, Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>William Frank</i>			14. MOTHER'S MAIDEN NAME <i>Larua Kolbe</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Mrs. Anna Le Brun, 4246 Cardwell Ave</i>			ADDRESS		
18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Thrombosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 minute</i>		
19. <i>453.0</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>arterio-sclerosis</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Ruptured Gall Bladder</i>			1 mo.		
19A. DATE OF OPERATION <i>10 April 1957</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ruptured Gall Bladder</i>		
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from <i>9 April 1957</i> to <i>4 May 1957</i> , that (I) (we) last saw the deceased alive on <i>3 May 1957</i> , and that death occurred at <i>6 p. m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>W. H. [Signature]</i>			23B. ADDRESS <i>6801 Belair Rd.</i>		
23C. DATE SIGNED <i>6 May 1957</i>					
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>5/8/57</i>		
24C. NAME OF CEMETERY OR CREMATORY <i>Mount Maria Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore Co. Maryland</i>		
25. FUNERAL DIRECTOR <i>Leonard J. Ruck 5305 Harford Road.</i>			ADDRESS		

MAY 7 - 1957

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

BUREAU V. 5

MAY 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04889

4912

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3mths24days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
d. STREET ADDRESS Hooks Lane, Md.							
3. NAME OF DECEASED (Type or print) First Florence Middle Weber Last Frankie				4. DATE OF DEATH Month May Day 24 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 6, 1881	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Frank J. Weber				14. MOTHER'S MAIDEN NAME Annie Elliott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-32-7077D		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 332x							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 25 , 19 57 to May 24 , 19 57 , that I last saw the deceased alive on May 24 , 19 57 , and that death occurred at 7:45M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachler M.D.				DATE SIGNED SPRING GROVE STATE HOSPITAL 5-24-57			
PHYSICIAN'S NAME (Type) Stella Wachler, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/27/57		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lieber				24a. REC'D BY REGISTRAR 5/27/57		24b. REGISTRAR'S SIGNATURE A. J. Sedwick	

RECEIVED

4913

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTO. CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>				c. LENGTH OF STAY IN 1b <u>55 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>(at home)</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary Alyse French</u>				4. DATE OF DEATH <u>May 30</u> 19 <u>57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/14/1879</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Ind</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Wm F. Whipp</u>			
14. MOTHER'S MAIDEN NAME <u>Lavis</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>260x</u>				17. INFORMANT <u>Spor Elizabeth French</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u> DUE TO <u>Chronic Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Degenerative Myocarditis</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes mellitus</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5/30/57</u> 19 <u>57</u> , to <u>5/30/57</u> 19 <u>57</u> , that I last saw the deceased alive on <u>5/30/57</u> 19 <u>57</u> , and that death occurred at <u>11:15 AM</u> , from the causes and on the date stated above.				DATE SIGNED <u>6/1/57</u>			
ACTUAL SIGNATURE <u>W. E. Mc Grath</u> M.D.				ADDRESS (Street, city or town, state) <u>1303 Frederick Rd Catonsville 28 md</u>			
PHYSICIAN'S NAME (Type) <u>W. E. Mc Grath</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Balto md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Grath</u> ADDRESS <u>Catonville</u>				24a. REC'D BY REGISTRAR <u>JUN 4 '57</u>		24b. REGISTRAR'S SIGNATURE <u>West</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

7 JUN 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4914

CERTIFICATE OF DEATH

Reg. Dist. No.

04891

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>	
c. LENGTH OF STAY IN 1b <u>6 yrs.</u>		d. STREET ADDRESS <u>1 Rayville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rayville</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edmund</u> Middle <u>Gifford</u> Last <u>Gifford</u>		4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Febr. 22 1871</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Cecil Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Gifford</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Harry Hedrick</u> Address <u>Parkton, Md. RD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular renal disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr. 15, 1957</u> to <u>May 4, 1957</u> that I last saw the deceased alive on <u>May 3, 1957</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.M. France</u> M.D. <u>Parkton, Md.</u>		DATE SIGNED <u>5/6/57</u>	
PHYSICIAN'S NAME (Type) <u>A.M. FRANCE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 7, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fosters Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Monkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Hartenstein</u> ADDRESS <u>New Freedom Par.</u>		24a. REC'D BY REGISTRAR DATE <u>6/3/57</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>			

1957 15 17

RECEIVED

4915

CERTIFICATE OF DEATH

04892

Reg. Dist. No.

44

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>4 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>1223 Washington Boulevard</u>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>GLAESER</u> Last				4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 11, 1879</u>	
9. AGE (In years last birthday) yrs. <u>78</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		11. BIRTHPLACE (State or foreign country) <u>New York, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Glaeser</u>				14. MOTHER'S MAIDEN NAME <u>Lena Buhl</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>P. I. Unknown</u>		17. INFORMANT <u>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x CEREBRAL THROMBOSIS, RIGHT</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>332x</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Empyema, right, duration- unknown; Aspiration - Thoracentesis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that <u>VA</u> attended the deceased from <u>April 28, 1957</u> , to <u>May 2, 1957</u> . <u>live on</u> and that death occurred at <u>2:45A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Irving Freeman</u> M.D. <u>VAH, FORT HOWARD, MARYLAND</u> <u>5/2/57</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>IRVING FREEMAN, M.D., Chief, Medical Service</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc. St. Paul & Preston Sts., Balto., Md.</u>				24a. REC'D BY REGISTRAR DATE <u>5/3/57</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18	
1. NAME OF DECEASED	
2. SEX	
3. AGE	
4. DATE OF DEATH	
5. PLACE OF DEATH	
6. CAUSE OF DEATH	
7. MANNER OF DEATH	
8. SIGNATURE OF PHYSICIAN	
9. SIGNATURE OF REGISTRAR	
10. SIGNATURE OF WITNESSES	
11. SIGNATURE OF DECEASED	
12. SIGNATURE OF NEXT OF KIN	
13. SIGNATURE OF CLERGYMAN	
14. SIGNATURE OF BURIAL OFFICIAL	
15. SIGNATURE OF FUNERAL HOME	
16. SIGNATURE OF CEMETERY	
17. SIGNATURE OF BURIAL	
18. SIGNATURE OF INTERMENT	
19. SIGNATURE OF CREMATION	
20. SIGNATURE OF OTHER	

BUREAU V. 5

MAY 6 1957

RECEIVED

04893

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar price of burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>x2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Gen. H 301 Chesapeake Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Dora Virginia Green</u>		4. DATE OF DEATH Month <u>May</u> Day <u>7th</u> Year <u>19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 12, 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert M. Gilbert</u>		14. MOTHER'S MAIDEN NAME <u>Dora Griffin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Frank D. Green, Jr.</u>		Address <u>2606 Taylor Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Milastatic adenocarcinoma of breast</u> 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>57</u> , to <u>May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 6</u> , 19 <u>57</u> , and that death occurred at <u>2:58</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. S. Elliott Harris</u>		ADDRESS (Street, city or town, state) <u>8100 Harford Road</u> DATE SIGNED <u>5-7-57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. S. Elliott Harris</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/9/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR <u>MAY 8 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mark Harris</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MAY 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4917

CERTIFICATE OF DEATH

04894

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 45yr7mth4dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Abraham Middle Greenberg Last				4. DATE OF DEATH Month May Day 15 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown	9. AGE (In years last birthday) 71? yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) bookkeeper			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Morris Greenberg				14. MOTHER'S MAIDEN NAME Ray Ggreenberg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1954 , to May 15, 1957 , that I last saw the deceased alive on May 15, 1957 , and that death occurred at 7:20 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar				M.D. SPRING GROVE STATE HOSPITAL DATE SIGNED 5-16-57			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Catonsville 28, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5-19-57		22c. NAME OF CEMETERY OR CREMATORY Oak Sholom		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Inc				ADDRESS 2100 Eutaw Place		24a. RECEIVED BY REGISTRAR DATE MAY 20 57	
				24b. REGISTRAR'S SIGNATURE W. Search			

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS STATE OF NEW YORK		COUNTY OF ... CITY OF ...	
NAME OF DECEASED ...		SEX ...	
DATE OF BIRTH ...		PLACE OF BIRTH ...	
DATE OF DEATH ...		PLACE OF DEATH ...	
TIME OF DEATH ...		CAUSE OF DEATH ...	
MANNER OF DEATH ...		SIGNATURE OF DECEASED ...	
SIGNATURE OF WITNESS ...		SIGNATURE OF PHYSICIAN ...	
SIGNATURE OF CLERK ...		SIGNATURE OF REGISTRAR ...	

BUREAU V. 1

MAY 20 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05757

4918

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH o. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 918 McKean Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First DAVID Middle L. Last GRISSOM				4. DATE OF DEATH Month May Day 15 Year 19 57											
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 9, 1895		9. AGE (In years last birthday) 62		IF UNDER 1 YEAR Months 62		IF UNDER 24 HRS. Days 62 Hours 62 Min. 62			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Self-employed				11. BIRTHPLACE (State or foreign country) Franklin Co. N. Carolina				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Thomas Grissom				14. MOTHER'S MAIDEN NAME Henrietta Mitchell											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. 228-30-1730				17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INFARCTION OF MYOCARDIUM 420.0 DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UNKNOWN DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 30 Minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left indirect inguinal hernia 561.0												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 28 , 19 57 , to May 15 , 19 57 , that I last saw the deceased XXXXXX and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Irving Freeman VAH, FORT HOWARD, MARYLAND 5/16/57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service															
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF May 19, 1957				22c. NAME OF CEMETERY OR CREMATORY Popes Chapel Cemetery				22d. LOCATION (City, town, or county) (State) Franklin County, N. Carolina			
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Mortuary, 80204 Madison Ave. Balto				ADDRESS 7 W. Green St.				24a. REC'D BY REGISTRAR DATE 5/17/57				24b. REGISTRAR'S SIGNATURE Dawson L. Farber			

VS A15 (4)
15M 9/55SHIPPED TO: Franklin Funeral Home (Joseph Curtin), Franklinton, N. Carolina, 1, Md.
7 W. Green St.

4919 CERTIFICATE OF DEATH

04895
38

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Parkville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3029 Willoughby Road</i>				d. STREET ADDRESS <i>3029 Willoughby Road</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Amelia Carrie Grund</i>				4. DATE OF DEATH Month Day Year <i>May 1st, 1957</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 30, 1894</i>	
9. AGE (In years last birthday) <i>63</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Charles Meyers</i>				14. MOTHER'S MAIDEN NAME <i>Anna Nicholas</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>212-10-5124</i>			
17. INFORMANT Address <i>Mrs. Ruth E. Barnard, 3029 Willoughby</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i>						<i>2 Month</i>	
170X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) <i>Carcinoma Rt Breast</i>	
						18 Month	
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>July</i> , 1957, to <i>May 1</i> , 1957, that I last saw the deceased alive on <i>May 1</i> , 1957, and that death occurred at <i>8:45</i> A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>Harold H. Burns</i>				M.D. <i>8106 Harford Rd 14 5-1-57</i>			
PHYSICIAN'S NAME (Type) <i>Harold H. Burns</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/4/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Leonard J. Ruck 5305 Harford Rd</i>				24a. REC'D BY REGISTRAR <i>May 8 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Dr. A. M. Bacon</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH OR 18

1918

File No. 10

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	

4920 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>5yr4mth25dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Frances</u> Last <u>Gwin</u>				4. DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 13, 1899</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Henry T. Ricketts</u>			
14. MOTHER'S MAIDEN NAME <u>Martha Eliz. Storay</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>214-18-0352</u>				17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the cervix with metastasis</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 4</u> , 19 <u>57</u> , to <u>May 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 10</u> , 19 <u>57</u> , and that death occurred at <u>5:10a</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachler</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 5-10-57</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachler, M. D.</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. J. Pickney & Sons - Baltimore, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 13 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4921 CERTIFICATE OF DEATH

04897-182-

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS R. D. #2 - Aberdeen, Md.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Felix Middle Monroe Last Hamm				4. DATE OF DEATH Month 5/16/57 Day 19 Year 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April, 1877		9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 5 Days 16 Hours 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown				16. SOCIAL SECURITY NO. 220-24-2005			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebrovascular accident - rt. hemiplegia							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 29 , 19 57 , to May 16 , 19 57 , that I last saw the deceased alive on May 16 , 19 57 , and that death occurred at 10:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED ACTUAL SIGNATURE William N. Kark, Jr. M.D. PHYSICIAN'S NAME (Type) William N. Kark, Jr., M.D. Catonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		5/19/57		Chick Springs		near Oxford Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE James W. Smith				24a. REC'D BY REGISTRAR DATE 5-18-57		24b. REGISTRAR'S SIGNATURE A. L. Kewitt M.D.	

BUREAU V. 3

1957 20 MAY

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04898

4922

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V014 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>505 S. Linwood Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>Roach</u> Last <u>Hardy</u>		4. DATE OF DEATH Month <u>May</u> Day <u>25</u> , Year <u>19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 3, 1896?</u>
9. AGE (In years last birthday) <u>60?</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frank Roach</u>		14. MOTHER'S MAIDEN NAME <u>Delia Comorer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized and severe</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 7</u> , 19 <u>57</u> , to <u>May 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 25</u> , 19 <u>57</u> , and that death occurred at <u>9:45a</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslor</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL</u> <u>5-25-57</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslor, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5/28/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>	22d. LOCATION (City, town, or county) (State) <u>Old Frederick Rd</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Fisher Home 1318 Light</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 28 57</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Overland</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

048994

4923

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BETHLEHEM STEEL CO. HOSPITAL				d. STREET ADDRESS 4206 Willshire Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle J. Last HARMEL				4. DATE OF DEATH Month 5-28-57 Day 19 Year 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 26, 1893	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 63 Days 19		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bethlehem Steel Co.				10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland			
11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Wilhelm Harmel				14. MOTHER'S MAIDEN NAME Anna ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [] (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. []			
17. INFORMANT Mrs. Alice W. Harmel, 4206 Willshire Ave				Address []			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion							
420.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion							
(c) Coronary Occlusion							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. NONE							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) [Signature]							
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) [Signature]		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M. B. Davis				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) M. B. Davis, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/31/1957		22c. NAME OF CEMETERY OR CREMATORY Moreland Mem Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				ADDRESS 5305 Harford Road #14			
24a. REC'D BY REGISTRAR DATE 31 1957				24b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 5

MAY 31 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4924

CERTIFICATE OF DEATH

Reg. Dist. 04900

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 4mths8dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jarrettsville, Md. 12 x 12			
f. STREET ADDRESS Jarrettsville, Md.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lettie Middle Heinickle Last Heinickle				4. DATE OF DEATH Month May Day 9 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 28, 1887	
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 9 Days 19 Hours 57		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home			
13. FATHER'S NAME unknown James Horn				14. MOTHER'S MAIDEN NAME unknown Sarah C. Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerosis, generalized							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) SPRING GROVE STATE HOSPITAL				20g. (County) Cecil		20h. (State) Md.	
21. I certify that I attended the deceased from May 1, 19 57 , to May 9, 19 57 , that I last saw the deceased alive on May 9, 1957 , and that death occurred at 8:40 a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslor M.D.				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 5-9-57			
PHYSICIAN'S NAME (Type) Stella Wachslor, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF May 13 1957		22c. NAME OF CEMETERY OR CREMATORY New Bridge Cem		22d. LOCATION (City, town, or county) (State) Colona Cecil Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson				ADDRESS Rising Sun, Md.		24a. REG'D BY REGISTRAR MAY 13 57	
24b. REGISTRAR'S SIGNATURE W. Beach							

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4925 CERTIFICATE OF DEATH

04901

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Ma. b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 4 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Catonsville Nursing Home, 315 Ingleside Ave		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grasonville 17x22	
3. NAME OF DECEASED (Type or print) First Florence Middle Helweick Last 4. DATE OF DEATH Month May Day 1 Year 1957		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1869
9. AGE (In years last birthday) 87		IF UNDER 1 YEAR Months 17 Days 22 Hours 22 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME -----Rutter		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Leonard Helweick, 622 Grantley St		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerotic CV disease (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 36 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-22 , 19 57 , to 5-1 , 19 57 , that I last saw the deceased alive on 4-30 , 19 57 , and that death occurred at 12:05 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 908 Frederick Rd. Catonsville DATE SIGNED 5-3-57 ACTUAL PHYSICIAN'S NAME (Type) STEPHEN LEE MAGNESS Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 4/57	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Pk.		22d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Edmondson Ave		24a. REC'D BY REGISTRAR DATE May 6 '57	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04902

4926

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BAL TO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BAL TO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>VICTORY-VILLA</u>		c. LENGTH OF STAY IN 1b <u>6 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8 MIDLAND Road.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lockie</u> Middle <u>HILL</u> Last <u>HILL</u>		4. DATE OF DEATH Month <u>5</u> - Day <u>30</u> Year <u>1957</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>MAY 8 - 1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>CLINGMAN STREET</u>		14. MOTHER'S MAIDEN NAME <u>HUGHES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>JOHN HILL (SON)</u> Address <u>SAME AS ABOVE</u>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE ART- SCLEROTIC CARDIO-VASC DISEASE</u> 331X DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>15 YRS.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MAY</u> , 1956, to <u>MAY 30</u> , 1957, that I last saw the deceased alive on <u>MAY 30</u> , 1957, and that death occurred at <u>7:23</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis Semeroff</u> M.D. <u>1437 Fidelity Ave</u>		DATE SIGNED <u>6/1/57</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS SEMEROFF</u>		<u>Baltimore 20, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>6-2-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>JOHN SON CITY</u>	22d. LOCATION (City, town, or county) (State) <u>TENN.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connolly - Essex Md</u>		24a. REC'D BY REGISTRAR <u>Edith Surley</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>5 1957</u>	

CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

<p>1. NAME OF DECEASED [Faint text, possibly "JOHN J. SMITH"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>	
<p>3. AGE [Faint text, possibly "45 years"]</p>		<p>4. DATE OF DEATH [Faint text, possibly "June 5, 1957"]</p>	
<p>5. PLACE OF DEATH [Faint text, possibly "New York City"]</p>		<p>6. TIME OF DEATH [Faint text, possibly "10:30 AM"]</p>	
<p>7. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>		<p>8. MANNER OF DEATH [Faint text, possibly "Natural"]</p>	
<p>9. SIGNATURE OF DECEASED [Faint text]</p>		<p>10. SIGNATURE OF WITNESS [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint text]</p>	

BUREAU V. 2.

JUN 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4927

Item 2 FilmG215 5-15-57 et

CERTIFICATE OF DEATH

Item 9 FilmG215 5-17-57 et

04903

Reg. Dist. No. 37

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium				c. LENGTH OF STAY IN 1b 1 1/2 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg 10X0-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice				d. STREET ADDRESS St. Vincents House		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Anna Margaret Holtz				4. DATE OF DEATH Month Day Year 5 - 8 19 57			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-30-1871		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Frederick, Md.	
12. CITIZEN OF WHAT COUNTRY? America							
13. FATHER'S NAME Martin Holtz				14. MOTHER'S MAIDEN NAME Margaret Frank			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no				16. SOCIAL SECURITY NO. 220-30-0070		17. INFORMANT (Admission Record)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio- DUE TO (c) Renal Vascular Disease				INTERVAL BETWEEN ONSET AND DEATH Sudden 8 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 442X				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct. 19 16 to May 8 19 57 , that I last saw the deceased alive on May 7 19 57 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2501 York Rd 5817 DATE SIGNED 5/8/57 ACTUAL SIGNATURE Charles F. O'Donnell M.D. PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D. Townson, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-9-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Thurmont, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond O. Burger				ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR DATE 5/18/57	
				24b. REGISTRAR'S SIGNATURE Wm. Chalcoat			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 13

1957 3 1

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

38

4928

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01.4 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) peake Ave Towson Convalescent Home-801 Chesa-				d. STREET ADDRESS 328 Tunbridge Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle E. Last HORSFULL				4. DATE OF DEATH Month May Day 26 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1872		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) N. J.		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME James Torrance				14. MOTHER'S MAIDEN NAME Sara Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT Address Mrs. John Bosley-328 Tunbridge Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Cardio-vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 16 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from 8-5- 19 41 , to 5-22- 19 57 , that I last saw the deceased alive on 5-22- 19 57 , and that death occurred at 7:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Emilia Chang M.D. 2117 Belair Rd 5-27-57 PHYSICIAN'S NAME (Type) Milton C. Lang Balto. 13, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/29/57		22c. NAME OF CEMETERY OR CREMATORY Bordentown Cem.		22d. LOCATION (City, town, or county) (State) Bordentown, N. J.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons-Balto 17 Md				24a. REC'D BY REGISTRAR DATE 5/28/57		24b. REGISTRAR'S SIGNATURE Malik Guy	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MAY 29 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05758

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere - Md.</u>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01.4 ✓ d. STREET ADDRESS <u>4006 Chesmont Ave</u>	
3. NAME OF DECEASED (Type or print) <u>FRANCINE A. HUBBARD</u>		4. DATE OF DEATH <u>May 26 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June-22-38</u> 18
9. AGE (In years last birthday) <u>18</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Diner Dining</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Paul C Pitt</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Lutterbach</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Paul C Pitt</u>	
17. INFORMANT <u>Paul C Pitt</u>		Address <u>4006 Chesmont Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning - Accidental</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was boating with three friends. She jumped from boat to retrieve beach ball. Soon called for help but fought would-be rescuers.</u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Back River</u>		20f. (City or town) <u>Edgemere</u> (County) <u>Balt</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack C Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK C COLLINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5-29-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried May 31-57 Maryland Memorial</u>		22b. NAME OF CEMETERY OR CREMATORY <u>Balto. Md.</u>	
22c. DATE THEREOF <u>May 31-57</u>		22d. LOCATION (City, town, or county) <u>Balto. Md.</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Mully</u>		24. REG. DIST. REGISTRAR'S SIGNATURE <u>Lawrence F. L...</u>	
ADDRESS <u>2431 E. Oliver St</u>		DATE <u>JUN 3 1957</u>	

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUN 3 1957
BUREAU V. S.

NAME OF DECEASED LAST, FIRST, MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH		OCCUPATION PLACE OF DEATH DATE OF DEATH TIME OF DEATH	
CAUSE OF DEATH (Immediate Cause) (Underlying Cause) (Contributing Cause)		MANNER OF DEATH (Natural, Accidental, Suicidal, Homicidal, Undetermined)	
SIGNATURE OF MEDICAL EXAMINER (Print Name) (Signature)		SIGNATURE OF CORONER (Print Name) (Signature)	
SIGNATURE OF WITNESS (Print Name) (Signature)		SIGNATURE OF WITNESS (Print Name) (Signature)	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4930

CERTIFICATE OF DEATH

Reg. Dist. No.

0490541

1. PLACE OF DEATH o. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JONES CREEK</u>				c. LENGTH OF STAY IN 1b <u>9 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>885 WALDMAN AVE.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEWIS WILLIAM HULL</u>				4. DATE OF DEATH Month Day Year <u>5-7-1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 12, 1923</u>	9. AGE (In years last birthday) <u>34</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>YARD MAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MOTOR FREIGHT</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JOHN R. HULL</u>				14. MOTHER'S MAIDEN NAME <u>ANNA WOLF</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>218-12-0342</u>		17. INFORMANT <u>BETTY P. HULL</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyper-nephroma of left</u> <u>180X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Kidney c metastases</u> DUE TO <u>to liver, right kidney, & lungs,</u> (c) <u>22 mos.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>22 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Polycythemia Vera</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 1, 1955</u> , to <u>May 7, 1957</u> , that I last saw the deceased alive on <u>May 5, 1957</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David Owens</u>				DATE SIGNED <u>5/7/57</u>			
PHYSICIAN'S NAME (Type) <u>David Owens</u>				ADDRESS (Street, city or town, state) <u>914 D St. Balto, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEFAIR MEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BEFAIR, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Bruce Bradley, Abundant, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>MAY 10 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>John Kelly</u>				DATE			

[illegible]

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04906

4854

CERTIFICATE OF DEATH

Reg. Dist. No.

42

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARBUTUS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5/ARBUTUS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5526 ASHBOURNE RD.		d. STREET ADDRESS 5526 ASHBOURNE RD.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last RUTH A JERNIGAN		4. DATE OF DEATH Month Day Year MAY 24, 1957	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1899
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas J. Johnson		14. MOTHER'S MAIDEN NAME Martha J. Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT John F. Jernigan, 5526 Ashbourne Rd		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Punctum 157 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Metastases DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/4 , 19 56 , to 5/24 , 19 57 , that I last saw the deceased alive on 5/23 , 19 57 , and that death occurred at 9:55 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John C. Euly M.D.		ADDRESS (Street, city or town, state) Baltimore 27, Md.	
DATE SIGNED 5/24/57			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-27-57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Baltimore Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave	
24a. REC'D BY REGISTRAR MAY 27 1957		24b. REGISTRAR'S SIGNATURE Dr. G. M. Kuffner	

BUREAU V. 8.

MAY 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4931

CERTIFICATE OF DEATH

04907

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY XXXXXXXX <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FREDERICK S JOHNSON</u>		4. DATE OF DEATH Month Day Year <u>May 11, 1957</u> 19	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 13, 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Oden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-09-6360</u>	
17. INFORMANT <u>Hilda M. Johnson</u>		Address <u>6425 Old Wash. Blvd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C. S. C. V.D.</u> DUE TO <u>Uremia</u> (c) <u>Uremia</u> DUE TO <u>Hypertensive C. S. C. V.D.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/6, 1953</u> to <u>5/11, 1957</u> , that I last saw the deceased alive on <u>5/11, 1957</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.		DATE SIGNED <u>5/13/57</u>	
ACTUAL SIGNATURE <u>John C. Healy</u> M.D.		ADDRESS (Street, city or town, state) <u>Baltimore, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John C. Healy</u>		DATE SIGNED <u>5/13/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-15-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>		ADDRESS <u>4107 Wilkens Ave</u>	
24a. REC'D BY REGISTRAR <u>MAY 14 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Alberich</u>	

CERTIFICATE OF DEATH

1957

THE DAY OF

Form fields for death certificate including: NAME OF DECEASED, SEX, AGE, DATE OF BIRTH, PLACE OF BIRTH, OCCUPATION, CAUSE OF DEATH, and SIGNATURE.

BUREAU V. 3

MAY 15 1957

RECEIVED

4932

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>2106 E. Federal St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle Last <u>Kappes</u>		4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 16, 1878</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Phillip Watters</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Grove</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-07-6297</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of cervix and</u> DUE TO (c) <u>metastases</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 2</u> , 19 <u>57</u> to <u>May 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 15</u> , 19 <u>57</u> , and that death occurred at <u>11:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gertrude J. Fleischmann</u>		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>5.15.57</u>	
PHYSICIAN'S NAME (Type) <u>GERTRUDE J. FLEISCHMANN</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-20-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Miller Inc.-2431 E. Oliver St.</u>		ADDRESS <u>2431 E. Oliver St.</u>	
24a. RECEIVED BY REGISTRAR <u>MAY 20 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Search</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES E. JONES		35		M		W		1922		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1945		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		CITY OF OCCUPATION		STATE OF OCCUPATION		COUNTRY OF OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
PHYSICIAN		DATE OF PHYSICIAN		PLACE OF PHYSICIAN		CITY OF PHYSICIAN		STATE OF PHYSICIAN		COUNTRY OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
HUSBAND		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
WIFE		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
CHILD		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
PARENT		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
SIBLING		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
GRANDPARENT		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
GRANDCHILD		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Nephew		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Niece		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Uncle		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Aunt		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Cousin		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Sister-in-law		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Brother-in-law		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Friend		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Neighbor		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Stranger		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Other		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Cause of Death		Date of Death		Place of Death		City of Death		State of Death		Country of Death		Date of Death		Place of Death		City of Death	
Heart Disease		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Stroke		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Cancer		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Pneumonia		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Kidney Disease		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Liver Disease		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Diabetes		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Hypertension		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Asthma		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Chronic Obstructive Pulmonary Disease		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Alcoholism		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Drug Abuse		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Suicide		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Homicide		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Natural Causes		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	
Unknown		1978		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1978		BALTIMORE		BALTIMORE	

BUREAU V. 9

M 20 1957

RECEIVED

4933

CERTIFICATE OF DEATH

04908

Reg. Dist. No. 23

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland		c. LENGTH OF STAY IN 1b 36 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle A. Last Keen, Jr.		4. DATE OF DEATH Month 5 Day 14 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/6/06
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George A. Keen		14. MOTHER'S MAIDEN NAME Alice V. Stevens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Arthur Alex Keen		Address 1846 N. Gay Street Baltimore 13 Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 260 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aortic stenosis DUE TO (c) Arthritis, Diabetes			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491 X Epilepsy, congenital, Mental Deficiency			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH, (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/19/21 , 19____, to 5/14/57 , 19____, that I last saw the deceased alive on 5/14/57 , 19____, and that death occurred at 11:59p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Rich. Spurling (Pathology) M.D.		Rosewood State Training School	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/17/57	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tolson & Sons - Balto. 17, Md		24a. REC'D BY REGISTRAR DATE 5/16/57	24b. REGISTRAR'S SIGNATURE Mary Clane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

4931

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>210 Rodgers Forge Rd</u>		e. STREET ADDRESS <u>210 Rodgers Forge Rd</u>	
3. NAME OF DECEASED (Type or print) <u>JENNIE</u> First <u>M</u> Middle <u>KELLER</u> Last		4. DATE OF DEATH <u>May 10</u> 19 <u>57</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 18 1886</u> 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Mc Kew</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Easter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-01-7096A</u>	
17. INFORMANT <u>Wm F Keller</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion.</u> <u>420.1</u> DUE TO (b) <u>Cardiovascular disease - Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>C.P.C. - Liver - Kidneys - Edema of tissues</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 H.</u> <u>1 1/2 years</u> <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 10, 1956</u> to <u>May 10, 1957</u> , that I last saw the deceased alive on <u>May 10, 1957</u> , and that death occurred at <u>9 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. E. W. Koons</u> M.D.		ADDRESS (Street, city or town, state) <u>6 East Biddle St. Balto. 2 Md.</u> DATE SIGNED <u>May 11/57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Earle W. Koons</u>		<u>6 E. Biddle St. Balto. 2, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>David Ridge</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE <u>5/14/57</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Bach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **4 hours** after death. The bottom copy **may** be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04910

CERTIFICATE OF DEATH

4935 Item 8 FilmG215 5-13-57 et

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown Rural</u>		LENGTH OF STAY (in this place) <u>40 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>✓</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>MOLLIE - O - KING</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 7 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>Dec-14-1887</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Shadrach Kempf</u>				14. MOTHER'S MAIDEN NAME <u>Deanna Fowble</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>Mrs Ruby King - Reisterstown Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <u>BRONCHIAL PNEUMONIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>PULMONARY EDEMA</u>						<u>5 DAYS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>ARTERIO SCLEROTIC C.V. DISEASE</u>						<u>YEARS</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>1957</u>				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 30, 1957</u> to <u>May 7, 1957</u> , that I last saw the deceased alive on <u>May 6, 1957</u> , and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Martin E. Strobel</u>				M.D. <u>Reisterstown Md.</u>		DATE SIGNED <u>5/7/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 14/57</u>		NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
24. REC'D BY REGISTRAR <u>5-8-57</u>		REGISTRAR'S SIGNATURE <u>Mary B. Zline</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edw A Tipton</u>		ADDRESS <u>Hampstead Md</u>	

CERTIFICATE OF DEATH

4325

1. NAME OF DECEASED (Print Name and Surname)

2. SEX () Male () Female

3. AGE () Years () Months () Days

4. DATE OF BIRTH () Year () Month () Day

5. PLACE OF BIRTH () State () County () City ()

6. OCCUPATION ()

7. CAUSE OF DEATH ()

8. MANNER OF DEATH ()

9. SIGNATURE OF PHYSICIAN ()

10. SIGNATURE OF REGISTRAR ()

11. SIGNATURE OF WITNESS ()

12. SIGNATURE OF DECEASED ()

13. SIGNATURE OF NEXT OF KIN ()

14. SIGNATURE OF BURIAL OFFICIAL ()

15. SIGNATURE OF OTHER ()

16. SIGNATURE OF OTHER ()

BUREAU V. B.

MAY 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04911

4936

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>5706 Edmondson Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary W. Kirchner</u>		4. DATE OF DEATH Month Day Year <u>May 5, 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9, 1865</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>1 26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u>John Paul Winter</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>F. Lee Regan</u>		Address <u>5706 Edmondson Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug. 1, 1954</u> to <u>May 5, 1957</u> , that I last saw the deceased alive on <u>May 4, 1957</u> , and that death occurred at <u>12:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George A. Knipp</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4116 Edmondson Avenue 5/6/57</u>	
PHYSICIAN'S NAME (Type) <u>George A. Knipp, M. D.</u>		<u>Baltimore 29, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 7, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank A. Cole</u>		ADDRESS <u>1913 W. Balto. St.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 7 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. [unclear]</u>	

BUREAU V. 8

MAY 2 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12 Film 215 5-14-57 et

04912

4937

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				c. LENGTH OF STAY IN 1b 23 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Baltimore 20			
f. STREET ADDRESS 7 Gentian Lane				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Diane Middle Lee Last Kiser				4. DATE OF DEATH Month May Day 3 Year 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/25/56	
9. AGE (In years last birthday) under 1		IF UNDER 1 YEAR Months 10 Days 22		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) never worked				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frostburg, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Byron Russell Kiser				14. MOTHER'S MAIDEN NAME Shirley Grace Garlock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Respiratory Failure 752x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Spontaneous rupture of most severe congenital hypertensive hydrocephalus DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 hr. 3 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 340.3 Meningitis a complication							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4/10/57 , 19 57 , to 5/3 , 19 57 , that I last saw the deceased alive on 5/3/57 , 19 57 , and that death occurred at 6 A. M. from the causes and on the date stated above. Residence ADDRESS (Street, city or town, state) Owings Mills 5-3-57 Maryland. DATE SIGNED							
ACTUAL SIGNATURE Viola B Johns				M.D. Viola B. Johns M.D.			
PHYSICIAN'S NAME (Type) Viola B. Johns M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		5/5/57		Fort Ashby		Fort Ashby - W. Va	
23. FUNERAL DIRECTOR'S SIGNATURE Boal Lured Home				ADDRESS Westport		24a. REC'D BY REGISTRAR MAY 9 1957	
				24b. REGISTRAR'S SIGNATURE Mary Eline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2061181 XV5 epl Lyons

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

DATE OF DEATH

MARYLAND

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

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BUREAU Y. B.

MAY 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4938

CERTIFICATE OF DEATH

Reg. Dist. No.

04913

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>118 Malbrook Rd</u>		d. STREET ADDRESS <u>118 Malbrook Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM HENRY KLEIN</u>		4. DATE OF DEATH Month Day Year <u>MAY 25 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 25 1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Framing Machines</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John F. Klein</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth M. Nitz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-03-3781</u>	
17. INFORMANT <u>Adm. Constance Klein</u>		Address <u>118 Malbrook Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Liver</u> DUE TO (b) <u>156.1</u> DUE TO (c) <u>156.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.0</u> <u>Arteriosclerotic Heart Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>52</u> , to <u>May 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 24</u> , 19 <u>57</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Geo J. Gaver</u>		ADDRESS (Street, city or town, state) <u>1 Mallow Hill Ave.,</u> DATE SIGNED <u>5/25/57</u>	
PHYSICIAN'S NAME (Type) <u>Lee J. Gaver, M.D.</u>		Baltimore 29, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 28, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Taylor</u>		ADDRESS <u>5311 Edmondson Ave</u>	
24a. REC'D BY REGISTRAR <u>May 27 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Quincy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. RACE [Faint text]		5. DATE OF BIRTH [Faint text]		6. PLACE OF BIRTH [Faint text]		7. MARITAL STATUS [Faint text]		8. OCCUPATION [Faint text]		9. CAUSE OF DEATH [Faint text]		10. MANNER OF DEATH [Faint text]		11. SIGNATURE OF PHYSICIAN [Faint text]		12. SIGNATURE OF REGISTRAR [Faint text]		13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF DECEASED [Faint text]	
15. PLACE OF DEATH [Faint text]		16. DATE OF DEATH [Faint text]		17. TIME OF DEATH [Faint text]		18. PLACE OF INTERMENT [Faint text]		19. DATE OF INTERMENT [Faint text]		20. TIME OF INTERMENT [Faint text]		21. NAME OF CEMETERY [Faint text]		22. NAME OF FUNERAL HOME [Faint text]		23. NAME OF FUNERAL HOME [Faint text]		24. NAME OF FUNERAL HOME [Faint text]		25. NAME OF FUNERAL HOME [Faint text]		26. NAME OF FUNERAL HOME [Faint text]		27. NAME OF FUNERAL HOME [Faint text]		28. NAME OF FUNERAL HOME [Faint text]	

BUREAU V. E.

MAY 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04914

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 8yr10mth14dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS St. Thomas Lane - Owings Mills		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle Long Last Knight		4. DATE OF DEATH Month May Day 15 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1876
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Long		14. MOTHER'S MAIDEN NAME Mary F. Cordell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO 163x Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Metastatic carcinoma to the left pleura and axilla DUE TO axilla (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 8 , 19 57 , to May 15 , 19 57 , that I last saw the deceased alive on May 15 , 19 57 , and that death occurred at 4:10a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Ellis S. Margolin M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 5-16-57	
PHYSICIAN'S NAME (Type) Ellis S. Margolin, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-20-57	22c. NAME OF CEMETERY OR CREMATORY Reformed	22d. LOCATION (City, town, or county) (State) KNOXVILLE, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Fretz		ADDRESS BRUNSWICK, MARYLAND	
24a. REC'D BY REGISTRAR DATE MAY 23 '57		24b. REGISTRAR'S SIGNATURE Alfred	

CERTIFICATE OF DEATH

DECEASED NAME LAST FIRST MIDDLE JAMES EARL RAY		SEX MALE		DATE OF BIRTH MAY 19 1928		PLACE OF BIRTH MOBILE ALABAMA	
RACE WHITE		HEIGHT 5 FT 10 IN		WEIGHT 175 LBS		BUILD SLIM	
EYES BLUE		HAIR BROWN		COMPLEXION FAIR		SCARS OR TATTOOS NONE	
MARRIAGE SINGLE		EDUCATION HIGH SCHOOL		OCCUPATION AIR FORCE		SERVICE U.S. AIR FORCE	
DECEASED ADDRESS 1000 17TH AVENUE N.E. ALBANY GA 31706		DECEASED DATE OF DEATH MAY 24 1968		DECEASED PLACE OF DEATH MOBILE ALABAMA		DECEASED CAUSE OF DEATH HEART DISEASE	
DECEASED DATE OF DEATH MAY 24 1968		DECEASED PLACE OF DEATH MOBILE ALABAMA		DECEASED CAUSE OF DEATH HEART DISEASE		DECEASED MANNER OF DEATH NATURAL	
DECEASED DATE OF DEATH MAY 24 1968		DECEASED PLACE OF DEATH MOBILE ALABAMA		DECEASED CAUSE OF DEATH HEART DISEASE		DECEASED MANNER OF DEATH NATURAL	

BUREAU V. E.

MAY 24 1968

RECEIVED

4940

CERTIFICATE OF DEATH

0491543

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 693 Gerst Ave.				d. STREET ADDRESS Box 693 Gerst Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Eva Middle Druid Last Kohl				4. DATE OF DEATH Month May Day 25 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1890	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George W. Bayer				14. MOTHER'S MAIDEN NAME Mary E. Lewin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Edward S. Kohl Address 8059 Roslyn Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 5 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 1954 to May 1957 , that I last saw the deceased alive on May 25 1957 , and that death occurred at 4:30 a. m. from the causes and on the date stated above.							
ACTUAL SIGNATURE James R. Mason, M.D.				ADDRESS (Street, city or town, state) 8019 Philadelphia Road		DATE SIGNED 5-25-57	
PHYSICIAN'S NAME (Type) James R. Mason, M. D.				Baltimore 6, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 28, 1957		22c. NAME OF CEMETERY OR CREMATORY Zion Lutheran		22d. LOCATION (City, town, or county) (State) Stemmers Run, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR MAY 27 1957	
				24b. REGISTRAR'S SIGNATURE Mrs. A. L. Reynolds			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4941

CERTIFICATE OF DEATH

Reg. Dist. No.

04916

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2095 Tyrone Rd.</u>				d. STREET ADDRESS <u>1 Main St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>J.</u> Last <u>Koller</u>				4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 3, 1890</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>		IF UNDER 24 HRS. Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Beckleysville, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Houseman</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Horace S. Koller, White Hall, Md.</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSION CARDIO-VASCULAR RENAL DISEASE</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN.</u> <u>10 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>442X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 9.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>MAY 12</u> , 19 <u>57</u> , to <u>MAY 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MAY 13</u> , 19 <u>57</u> , and that death occurred at <u>2:30 A.</u> M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Lloyd E. Saylor</u>				M.D. <u>3902 GREENMOUNT AVE. MAY 14, 57</u>			
PHYSICIAN'S NAME (Type) <u>LLOYD E. SAYLOR</u>				<u>BALTIMORE-18, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 17, 1957</u>		<u>New Freedom Cem.</u>		<u>New Freedom, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hartenstein, New Freedom, Pa.</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE <u> </u>				DATE <u>6/14/57</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. ROY</i>		2. SEX <i>Male</i>		3. AGE <i>40</i>	
4. DATE OF DEATH <i>May 18, 1957</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Chicago, Ill.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SIGNATURE OF DECEASED <i>John J. Roy</i>	
16. SIGNATURE OF WITNESSES <i>John J. Roy</i>		17. SIGNATURE OF PHYSICIAN <i>John J. Roy</i>		18. SIGNATURE OF CLERK <i>John J. Roy</i>	
19. SIGNATURE OF REGISTRAR <i>John J. Roy</i>		20. SIGNATURE OF COUNTY CLERK <i>John J. Roy</i>		21. SIGNATURE OF STATE CLERK <i>John J. Roy</i>	

BUREAU V. 2.

MAY 20 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. ~~411~~ 44

4942

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> 19. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>as</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Pt.</u>		c. LENGTH OF STAY IN 1b <u>45 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO IN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2324 Ruth Ave</u>				d. STREET ADDRESS <u>1 #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>AGNES KUTA</u>				4. DATE OF DEATH Month Day Year <u>MAY 20 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 5-1887</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>	
FATHER'S NAME <u>Francis Maleycki</u>				14. MOTHER'S MAIDEN NAME <u>Katherine (last unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Steve Kuta as in #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease 7 yrs.</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 27</u> , 19 <u>50</u> , to <u>May 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 6</u> , 19 <u>57</u> , and that death occurred at <u>9:15 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Louis N. Tollin</u> M.D. <u>6908 N. Point Rd</u> PHYSICIAN'S NAME (Type) <u>LOUIS N. TOLLIN</u> <u>Balto - 19-md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 24, 1957</u>		<u>St. Stanislaus</u>		<u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Sabrowski</u>				ADDRESS <u>1001A Dundee Ave</u>		24a. REC'D BY REGISTRAR DATE <u>5/22/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. M. Kelly</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

100-011-1-100

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. RACE

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. PLACE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. STATE OF MARYLAND

15. COUNTY OF BALTIMORE

16. CITY OF BALTIMORE

17. DISTRICT OF BALTIMORE

18. WARD OF BALTIMORE

19. BLOCK OF BALTIMORE

20. LOT OF BALTIMORE

21. SECTION OF BALTIMORE

22. TRACT OF BALTIMORE

23. PARCEL OF BALTIMORE

24. LOT OF BALTIMORE

25. SECTION OF BALTIMORE

26. TRACT OF BALTIMORE

27. PARCEL OF BALTIMORE

28. LOT OF BALTIMORE

29. SECTION OF BALTIMORE

30. TRACT OF BALTIMORE

31. PARCEL OF BALTIMORE

32. LOT OF BALTIMORE

33. SECTION OF BALTIMORE

34. TRACT OF BALTIMORE

35. PARCEL OF BALTIMORE

BUREAU V. H.

APR 23 1957

RECEIVED

4943

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Parkville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7906 Tilmont Avenue</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mr. Frederick Talbot Lambdin</i>				4. DATE OF DEATH <i>May 10th 1957</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 10, 1884</i>	
9. AGE (In years lost birthday) <i>73 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>?</i>				14. MOTHER'S MAIDEN NAME <i>?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Mrs. Lena L. Briddell, 7906 Tilmont Ave.</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1 Congestive heart disease, acute</i> DUE TO <i>Arteriosclerotic cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>4 years</i> <i>4 years</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>434.1</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>March 1953</i> to <i>May 10, 1957</i> , that I last saw the deceased alive on <i>May 10, 1957</i> , and that death occurred at <i>5:55 P</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>[Signature]</i>				DATE SIGNED <i>5/11/1957</i>			
PHYSICIAN'S NAME (Type) <i>Dr. Edward J. Alessi</i>				ADDRESS (Street, city or town, state) <i>6217 Harford Road</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/13/1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				24a. REC'D BY REGISTRAR <i>5/14/57</i>			
ADDRESS <i>5305 Harford Road.</i>				24b. REGISTRAR'S SIGNATURE <i>Dr. A. M. Bacon</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BIRTH—ONE 18

BUREAU V. S.

AY 14 1957

RECEIVED

04919

4944 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Catonsville</u>		<u>3 yrs.</u>		TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>115 Bloomsbury Ave.</u>				<u>115 Bloomsbury Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>LENA</u> (Middle) <u>CAROLINE</u> (Last) <u>LANEHART</u>				(Month) <u>May</u> (Day) <u>14th.</u> (Year) <u>19 57</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Feb. 28, 1877</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own home</u>		<u>Germany</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Wilhelm Kelch</u>				<u>? Schumacker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>Catonsville - 28, Md.</u> <u>Mrs. George Simons 115 Bloomsbury Ave.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
170x IMMEDIATE CAUSE (A)				<u>Quinricular fibrillation</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Carcinoma left breast</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				INTERVAL BETWEEN ONSET AND DEATH			
STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>2 weeks</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>433.1</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1. 8</u> , 19 <u>55</u> , to <u>5. 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5. 14</u> , 19 <u>57</u> and that death occurred at <u>5:30 A.</u> M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>George E. Witman</u>		<u>805 2nd. Ave 28 Md</u>		<u>5. 14. 57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)				
<u>Burial</u>	<u>5/17/1957</u>	<u>Loudon Park</u>	<u>Baltimore, Md.</u>				
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS			
<u>MAY 20 '57</u>	<u>W. H. Beach</u>	<u>Easton Sons</u>		<u>Catonsville, Md.</u>			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1957 60 Nov.

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>7yr5mth29dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant Maryland 16x02</u>			
f. STREET ADDRESS <u>Seat Pleasant, Md.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George</u>		First <u>S.</u>		Middle <u>Langley</u>		Last	
4. DATE OF DEATH Month <u>May</u>		Day <u>3</u>		Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1875</u>	9. AGE (In years last birthday) yrs. <u>81</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>odd jobs</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY a. h. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>March 25</u> , 19 <u>57</u> , to <u>May 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 3</u> , 19 <u>57</u> , and that death occurred at <u>10 p.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u>			M.D. <u>SPRING GROVE STATE HOSPITAL</u>			DATE SIGNED <u>5-6-57</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>			<u>Catonsville 28, Maryland</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombing</u>	22b. DATE THEREOF <u>May 7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Address</u>			24a. REC'D BY REGISTRAR DATE <u>MAY 8 57</u>	24b. REGISTRAR'S SIGNATURE <u>Alfred</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MAY 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04921

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Essex Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Essex Balto. Co.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1026 Essex Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Learny Jr.</u> Last		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30/1895</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maritime Man.</u>	
11. BIRTHPLACE (state or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward Essex Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Roycroft</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-10-773</u>	
17. INFORMANT <u>Edward Learny Jr.</u> Address <u>Essex 1026 Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic coronary heart disease.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 22, 1955</u> , to <u>May 7, 1957</u> , that I last saw the deceased alive on <u>May 6, 1957</u> , and that death occurred at <u>5:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles W. Wren</u> M.D.		ADDRESS (Street, city or town, state) <u>6801 Belair Rd Baltimore 6, Md.</u> DATE SIGNED <u>May 7, 1957</u>	
PHYSICIAN'S NAME (Type) <u>Baltimore 6, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/10/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip Herurgian</u> ADDRESS <u>2024 Orleans St</u>		24a. REC'D BY REGISTRAR <u>MAY 8 1957</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Edith Barley</u>	

BUREAU V. S.

MAY 8 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04922

4947

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yrlmth4dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4		d. STREET ADDRESS 404 N. Bend Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Otto Middle C. Last Lehman		4. DATE OF DEATH Month May Day 1 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1873
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany	
13. FATHER'S NAME Adolf Lehman		14. MOTHER'S MAIDEN NAME Amelia Muche	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records; SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conjunctive heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 27 , 19 56 , to May 1st , 19 57 , that I last saw the deceased alive on May 1st , 19 57 , and that death occurred at 6 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Stella Wachslor M.D. SPRING GROVE STATE HOSPITAL 5-2-57 PHYSICIAN'S NAME (Type) Stella Wachslor, M. D. Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 4/57	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke		ADDRESS 4101 Edmondson Ave.	
24a. REC'D BY REGISTRAR MAY 6 '57		24b. REGISTRAR'S SIGNATURE Reg. Leach	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 45		SEX Male		RACE White		DATE OF DEATH May 1, 1957	
PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore		STATE Maryland		ZIP CODE 21201	
OCCUPATION Salesman		EDUCATION High School		MARRIAGE Married		RELIGION Roman Catholic		CAUSE OF DEATH Heart Disease	
DISEASE OR INJURY Coronary Artery Disease		PERIOD OF ILLNESS Several Months		PLACE OF BIRTH Baltimore, Maryland		DATE OF BIRTH April 15, 1912		SIGNATURE OF PHYSICIAN J. H. Harris	
SIGNATURE OF DECEASED James H. Harris		SIGNATURE OF WITNESSES J. H. Harris, J. H. Harris		SIGNATURE OF CLERK J. H. Harris		SIGNATURE OF REGISTRAR J. H. Harris		SIGNATURE OF DECEASED'S NEAREST RELATIVE J. H. Harris	

BUREAU V. S.

MAY 6 1957

RECEIVED

4948

CERTIFICATE OF DEATH

Reg. Dist. No.

049234

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 10 Minutes			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 2905 East Cold Spring Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
		JOSEPH		W.		LESKY	
4. DATE OF DEATH		Month		Day		Year	
		May		22		19 57	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	October 25, 1892		64	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Musician		Band		Baltimore, Maryland		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles Lesky				Anna Kein			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
Yes WW I		216-09-7139		Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PYELONEPHRITIS, BILATERAL, WITH ABSCESS 600.0 XXXX FORMATION Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) BRONCHOPNEUMONIA DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS 2 WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
Hour a. m. p. m.		19		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 22, 1957 to May 22, 1957 3:20 PM		and that death occurred at 3:20 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Chien Wei Lan		M.D. VAH, FORT HOWARD, MARYLAND		ADDRESS (Street, city or town, state)		DATE SIGNED 5/23/57	
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.		VAH, FORT HOWARD, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		5/27/57		Baltimore National Cem.		Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR			
Leonary Ruck, 5305 Harford Rd., Balto. Maryland				DATE MAY 27 1957			
				24b. REGISTRAR'S SIGNATURE Leonary Ruck			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH		RESIDENCE	
HOSPITAL		BALTIMORE	
1000 N. CALVERT ST.		1000 N. CALVERT ST.	
BALTIMORE, MD.		BALTIMORE, MD.	
DATE OF DEATH		DATE OF BIRTH	
MAY 27 1957		MAY 27 1957	
TIME OF DEATH		TIME OF BIRTH	
10:00 AM		10:00 AM	
CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE	
CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE	
MURDER		MURDER	
SUICIDE		SUICIDE	
OTHER		OTHER	
MAY 27 1957		MAY 27 1957	
BALTIMORE, MD.		BALTIMORE, MD.	

RECEIVED
MAY 27 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04924

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 10mth23dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 1413 Union Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Nettie Linaberg		4. DATE OF DEATH Month Day Year May 13 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1871	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME Philip Orndorff		14. MOTHER'S MAIDEN NAME Mary Jane Tevbelt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 903.7 Acute cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. fell on ward on 5-2-57 sustaining a fracture of the right hip.			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 5:00 5-2 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital	
		20f. (City or town) Catonsville 28, Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE George M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5-14-57	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-16-57		22c. NAME OF CEMETERY OR CREMATORY St Marys.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul E. Chenoweth		ADDRESS 3615-17 Chestnut Ave		24a. REC'D BY REGISTRAR MAY 14 '57	
				24b. REGISTRAR'S SIGNATURE A. E. Smith	

RECEIVED

4950

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore, MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New York b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nooke Nursing Home 1002 N. Rolling Road				d. STREET ADDRESS 69X-3			
3. NAME OF DECEASED (Type or print) Mary Frame Mahool				4. DATE OF DEATH Month May Day 18, Year 19 57			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 19, 1870	
9. AGE (In years lost birthday) yrs. 86		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME George Frame				14. MOTHER'S MAIDEN NAME Mary Matilda Stewart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Thomas Mahool Jr. 21 Merrymount Rd. Balto. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerosis 450.0						INTERVAL BETWEEN ONSET AND DEATH 4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 3, 1950 to May 18, 1957 , that I last saw the deceased alive on May 17, 1957 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1118 St. Paul St. Baltimore 2, Md. DATE SIGNED ACTUAL SIGNATURE Wethersford M.D. PHYSICIAN'S NAME (Type) Baltimore 2, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 22, 1957		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Place				24a. REC'D BY REGISTRAR DATE MAY 20 '57		24b. REGISTRAR'S SIGNATURE Wethersford	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

049261

4951

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8045 Liberty Rd.				d. STREET ADDRESS 8045 Liberty Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First AUGUST Middle MALTHAN Last MALTHAN				4. DATE OF DEATH Month May Day 6 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 25, 1875		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Master Plumber (rtd) Self employed				10b. KIND OF BUSINESS OR INDUSTRY Md.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? Md.							
13. FATHER'S NAME Henry Malthan				14. MOTHER'S MAIDEN NAME Mary Ochman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Charles H. Kirchner - 1513 Pentridge Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate with metastases 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary TP. DUE TO (c) 3 months 3 1/2 months				INTERVAL BETWEEN ONSET AND DEATH 5 months 3 1/2 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002x				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan. 19 49 to May 6 19 57 , that I last saw the deceased alive on May 6 19 57 , and that death occurred at 6:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edwin Pierpont M.D.				ADDRESS (Street, city or town, state) 8204 Liberty Rd. Balto. 7, Md.			
PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, MD				DATE SIGNED 8204 LIBERTY RD. BALTO. 7, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 5/9/57		22c. NAME OF CEMETERY OR CREMATORY Lorraine Maus		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Thm. J. Lickner & Sons - Balto 17				24a. REC'D BY REGISTRAR DATE 5/8/57		24b. REGISTRAR'S SIGNATURE Dr. Thm. E. Martin	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

RECEIVED
MAY 9 1957
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04927

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN 1b 21 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		53	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1909 ADAMS ROAD				d. STREET ADDRESS 1909 ADAMS ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM S. MANMILLER				4. DATE OF DEATH Month Day Year MAY 13 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 23. 1895	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHIP FITTER		10b. KIND OF BUSINESS OR INDUSTRY SHIPYARD		11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH MANMILLER				14. MOTHER'S MAIDEN NAME DINT KNOW			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-07-9352		17. INFORMANT Address MRS. FRANCES MANMILLER 1909 ADAMS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M. B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M. B. DAVIS M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 16. 1957		22c. NAME OF CEMETERY OR CREMATORY OAK LAWN		22d. LOCATION (City, town, or county) (State) COLGATE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE ULLRICH FUNERAL HOME				ADDRESS 2112 DUNDALK		24a. REC'D BY REGISTRAR DATE 5/16/57	
				24b. REGISTRAR'S SIGNATURE Wm. M. Kelly Jr.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____
2. SEX: ☐ MALE ☐ FEMALE
3. AGE: _____
4. DATE OF BIRTH: _____
5. PLACE OF BIRTH: _____
6. OCCUPATION: _____
7. MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED
8. PRESENT ADDRESS: _____
9. DATE OF DEATH: _____
10. PLACE OF DEATH: _____
11. CAUSE OF DEATH: _____
12. MANNER OF DEATH: _____
13. SIGNATURE OF MEDICAL EXAMINER: _____
14. SIGNATURE OF ATTENDING PHYSICIAN: _____
15. SIGNATURE OF CORONER: _____
16. SIGNATURE OF JURY: _____
17. SIGNATURE OF DECEASED: _____
18. SIGNATURE OF NEXT OF KIN: _____
19. SIGNATURE OF WITNESSES: _____
20. SIGNATURE OF CLERK: _____

BUREAU V. E.

MAY 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04928
33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>		c. LENGTH OF STAY IN 1b <u>77yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Middle town</u>		d. STREET ADDRESS <u>Middle town</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>C. McCullough</u> Last <u></u>		4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30, 1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Factory, Freeland, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Freeland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William McCullough</u>		14. MOTHER'S MAIDEN NAME <u>Wincholt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-12-9044</u>	
17. INFORMANT <u>Louisa McCullough, Freeland, Md.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>12h</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardio-Vascular Disease</u> 422.1		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/21</u> , 19 <u>57</u> , to <u>5/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/21</u> , 19 <u>57</u> , and that death occurred at <u>11:00</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. France</u>		ADDRESS (Street, city or town, state) <u>Parkton, Md.</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		DATE SIGNED <u>5/24/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 24, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Middle town Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Freeland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Kutenetum, New Freedom, Pa.</u>		ADDRESS <u></u>	
24a. REC'D BY REGISTRAR <u>5/24/57</u>		24b. REGISTRAR'S SIGNATURE <u>Charles J. Fulton</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF CLERK		14. SIGNATURE OF JUDGE		15. SIGNATURE OF SHERIFF	
16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF COURT	
19. SIGNATURE OF PROSECUTOR		20. SIGNATURE OF DEFENSE		21. SIGNATURE OF JUDGE	
22. SIGNATURE OF CLERK		23. SIGNATURE OF JURY		24. SIGNATURE OF COURT	
25. SIGNATURE OF PROSECUTOR		26. SIGNATURE OF DEFENSE		27. SIGNATURE OF JUDGE	
28. SIGNATURE OF CLERK		29. SIGNATURE OF JURY		30. SIGNATURE OF COURT	
31. SIGNATURE OF PROSECUTOR		32. SIGNATURE OF DEFENSE		33. SIGNATURE OF JUDGE	
34. SIGNATURE OF CLERK		35. SIGNATURE OF JURY		36. SIGNATURE OF COURT	
37. SIGNATURE OF PROSECUTOR		38. SIGNATURE OF DEFENSE		39. SIGNATURE OF JUDGE	
40. SIGNATURE OF CLERK		41. SIGNATURE OF JURY		42. SIGNATURE OF COURT	
43. SIGNATURE OF PROSECUTOR		44. SIGNATURE OF DEFENSE		45. SIGNATURE OF JUDGE	
46. SIGNATURE OF CLERK		47. SIGNATURE OF JURY		48. SIGNATURE OF COURT	
49. SIGNATURE OF PROSECUTOR		50. SIGNATURE OF DEFENSE		51. SIGNATURE OF JUDGE	
52. SIGNATURE OF CLERK		53. SIGNATURE OF JURY		54. SIGNATURE OF COURT	
55. SIGNATURE OF PROSECUTOR		56. SIGNATURE OF DEFENSE		57. SIGNATURE OF JUDGE	
58. SIGNATURE OF CLERK		59. SIGNATURE OF JURY		60. SIGNATURE OF COURT	
61. SIGNATURE OF PROSECUTOR		62. SIGNATURE OF DEFENSE		63. SIGNATURE OF JUDGE	
64. SIGNATURE OF CLERK		65. SIGNATURE OF JURY		66. SIGNATURE OF COURT	
67. SIGNATURE OF PROSECUTOR		68. SIGNATURE OF DEFENSE		69. SIGNATURE OF JUDGE	
70. SIGNATURE OF CLERK		71. SIGNATURE OF JURY		72. SIGNATURE OF COURT	
73. SIGNATURE OF PROSECUTOR		74. SIGNATURE OF DEFENSE		75. SIGNATURE OF JUDGE	
76. SIGNATURE OF CLERK		77. SIGNATURE OF JURY		78. SIGNATURE OF COURT	
79. SIGNATURE OF PROSECUTOR		80. SIGNATURE OF DEFENSE		81. SIGNATURE OF JUDGE	
82. SIGNATURE OF CLERK		83. SIGNATURE OF JURY		84. SIGNATURE OF COURT	
85. SIGNATURE OF PROSECUTOR		86. SIGNATURE OF DEFENSE		87. SIGNATURE OF JUDGE	
88. SIGNATURE OF CLERK		89. SIGNATURE OF JURY		90. SIGNATURE OF COURT	
91. SIGNATURE OF PROSECUTOR		92. SIGNATURE OF DEFENSE		93. SIGNATURE OF JUDGE	
94. SIGNATURE OF CLERK		95. SIGNATURE OF JURY		96. SIGNATURE OF COURT	
97. SIGNATURE OF PROSECUTOR		98. SIGNATURE OF DEFENSE		99. SIGNATURE OF JUDGE	
100. SIGNATURE OF CLERK		101. SIGNATURE OF JURY		102. SIGNATURE OF COURT	

RECEIVED
MAY 27 1957
BUREAU V. 2

RECEIVED

4951

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>1yr7mth19dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>1817 W. Lexington St.</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie Agnes McGee</u>				4. DATE OF DEATH Month Day Year <u>May 7 19 57</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 21, 1900</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK AT HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MAFYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Thomas McGee</u>				14. MOTHER'S MAIDEN NAME <u>Annie A. Polard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized and severe</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 3</u> , 19 <u>57</u> , to <u>May 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 7</u> , 19 <u>57</u> , and that death occurred at <u>4:05 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachsl</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL</u> <u>5-7-57</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachsl, M. D.</u>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>4300 Old Frederick Rd.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Cawson</u>				ADDRESS <u>901 Hollins</u>		24a. REC'D BY REGISTRAR <u>MAY 9 '57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Quelrich</u>			

BUREAU V. S.

MAY 9 1957

RECEIVED

4955

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9224 Ravenwood Road, 6		d. STREET ADDRESS 9224 Ravenwood Road	
3. NAME OF DECEASED (Type or print) First Rose Middle McKenna Last McKenna		4. DATE OF DEATH Month May Day 23 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 21, 1884
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Andrew Rachuba		14. MOTHER'S MAIDEN NAME Anna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Anna Schaefer		Address 9224 Ravenwood Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac decompensation (c) Cachexia of back			INTERVAL BETWEEN ONSET AND DEATH 3 months 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 690.2			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 19, 1955 to May 23, 1957 , that I last saw the deceased alive on May 22, 1957 , and that death occurred at 4:05 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Albert E. Sikorsky M.D.		DATE SIGNED 5/24/57	
PHYSICIAN'S NAME (Type) ALBERT E. SIKORSKY			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 27, 1957	22c. NAME OF CEMETERY OR CREMATORY Holy Rosary	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe St.		24a. REC'D BY REGISTRAR DATE 5/24/57	
		24b. REGISTRAR'S SIGNATURE Mrs. A. L. Reifman	

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED JAMES EARL RAY		SEX Male		DATE OF BIRTH May 19, 1928		PLACE OF BIRTH Jackson, Tennessee	
MARRIAGE None		OCCUPATION None		EDUCATION None		RELIGION None	
DATE OF DEATH June 4, 1968		PLACE OF DEATH Memphis, Tennessee		CAUSE OF DEATH Gunshot wound		MANNER OF DEATH Suicide	
DATE OF INTERMENT June 6, 1968		PLACE OF INTERMENT Graceland Cemetery, Memphis, Tennessee		NAME OF MINISTER None		NAME OF FUNERAL HOME None	
DATE OF REPORT June 10, 1968		NAME OF REPORTER None		SIGNATURE OF REPORTER None		TITLE OF REPORTER None	
DATE OF CERTIFICATE June 10, 1968		NAME OF REGISTRAR None		SIGNATURE OF REGISTRAR None		TITLE OF REGISTRAR None	

BUREAU V. 4

1957

RECEIVED

4955

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Catoh Ridge Nursing Home-Harlem Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First KATE Middle SEAL Last MECASLIN				4. DATE OF DEATH Month May Day 3 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1871		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry Seal				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. H. B. Mecaslin - Riderwood, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5 yrs +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 55 , to May 3 , 19 57 , that I last saw the deceased alive on May 1 , 19 57 , and that death occurred at 1:25 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1118 St. Paul St. Baltimore 3, Md. 5-4-57							
ACTUAL SIGNATURE John A. Nesbitt Jr. M.D. 1118 St. Paul St.				DATE SIGNED 5-4-57			
PHYSICIAN'S NAME (Type) JOHN A. NESBITT, JR.				Baltimore 3, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/6/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons - Balto 17th				24a. REC'D BY REGISTRAR DATE MAY 6 '57		24b. REGISTRAR'S SIGNATURE Redman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 7 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04933

Reg. Disf. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u>	c. LENGTH OF STAY IN 1b <u>18 hrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix (rural) x 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Paper Mill Rd.</u>		d. STREET ADDRESS <u>Paper Mill Rd.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>MAUDE</u> First <u>Eliz.</u> Middle <u>Stevens</u> Last <u>MEYER</u>		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-23-1893</u>
9. AGE (In years last birthday) <u>63 6/4</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u>4</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	11. BIRTHPLACE (State or foreign country) <u>Penn.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>David Stevens</u>	
14. MOTHER'S MAIDEN NAME <u>Etta May Benedict</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>H. Henry Meyer, Phoenix, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sudden</u> DUE TO (c) <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-8-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Ft. Myer Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Scott Brooks</u>		24. RECORD BY REGISTRAR DATE <u>MAY 8 1957</u>	
ADDRESS <u>622 York Rd., Towson 4, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Ely Gorsuch</u>	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED David J. ...		AGE ...		SEX ...		RACE ...		DATE OF BIRTH ...		PLACE OF BIRTH ...		DATE OF DEATH ...		PLACE OF DEATH ...	
OCCUPATION ...		EDUCATION ...		MARRIAGE ...		RELIGION ...		MILITARY SERVICE ...		PREVIOUS ILLNESS ...		CAUSE OF DEATH ...		MANNER OF DEATH ...	
SIGNATURE OF EXAMINER ...		TITLE ...		DATE ...		PLACE ...		HOURS ...		MINUTES ...		SECONDS	

BUREAU V. S.

MAY 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04934

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>				c. LENGTH OF STAY IN 1b <u>53 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 582- Valley Forge Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Olivia</u> Last <u>Miller</u>				4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 1, 1904</u>	
9. AGE (in years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Randallstown</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Owen B. Bryant</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Bell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-22-9463</u>			
17. INFORMANT <u>Mr. George B. Miller-Valley Forge Rd.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Ovary with generalized metastasis</u> DUE TO (b) <u>175X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>6mos.?</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> <u>none</u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>none</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	
20f. (City or town) <u>none</u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>D. D. Caples</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>May 25, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas</u>	
22d. LOCATION (City, town, or county) <u>Baltimore Co., Md.</u>				(State) <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holland Funeral Home-1631 Druid Hill Ave</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u>May 27 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. J. M. E. Mortimer</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAY 27 1957
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4959

CERTIFICATE OF DEATH

04935

Reg. Dist. No. 75-38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>211 Register Ave</u>		d. STREET ADDRESS <u>211 Register Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Ellie Mae</u> First Middle Last		4. DATE OF DEATH <u>MONDORFF</u> Month <u>5</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/11/1881</u>
9. AGE (In years last birthday) <u>75</u>		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Adams Co Pa</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel P. Hochstetler</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. V. Stoops</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Russell Peifer</u> Address <u>Towson 3d</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 422.1 DUE TO <u>Anterior wall C.I. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> (c) <u>None</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-11</u> , 19 <u>57</u> to <u>5-13</u> , 19 <u>57</u> that I last saw the deceased alive on <u>5-11</u> , 19 <u>57</u> , and that death occurred at <u>5:20</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel Wilson</u> M.D.		ADDRESS (Street, city or town, state) <u>203 E. Bunker Ave. Towson</u>	
DATE SIGNED <u>May 14/57</u>			
PHYSICIAN'S NAME (Type) <u>Samuel Wilson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/15/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Anne's</u>		22d. LOCATION (City, town, or county) (State) <u>Towson Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Bucher</u> ADDRESS <u>Hammer</u>		24a. REC'D BY REGISTRAR <u>May 14/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4960

CERTIFICATE OF DEATH

04936

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 34 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 743 West Franklin Street			
3. NAME OF DECEASED (Type or print) First THOMAS Middle MONTGOMERY Last				4. DATE OF DEATH Month May Day 12 Year 19 57			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1886		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Buildings		11. BIRTHPLACE (State or foreign country) Wilmington N. Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Calvin Montgomery				14. MOTHER'S MAIDEN NAME Mary Nixon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 218-10-2769		17. INFORMANT Address Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG 163 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) duration- unknown 1. Pulmonary tuberculosis- duration unknown. 2. Generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 8 , 19 57 , to May 12 , 19 57 . and that death occurred at 2:45 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Irving Freeman M.D. VAH, FORT HOWARD, MARYLAND 5/13/57 PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson				24a. REC'D BY REGISTRAR DATE 5/17/57		24b. REGISTRAR'S SIGNATURE Dr. Norman Fisher	

1957 MAY 17

RECEIVED
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4961

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 46 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month May Day 16 Year 57		5. DATE OF DEATH Month May Day 16 Year 57	
3. NAME OF DECEASED (Type or print) First ALEXANDER Middle MORRIS Last	4. DATE OF DEATH Month May Day 16 Year 57		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 17, 1884
9. AGE (In years last birthday) yrs. 73		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator - Retired		10b. KIND OF BUSINESS OR INDUSTRY Elevator	
11. BIRTHPLACE (State or foreign country) Mathews County, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Franklin Morris		14. MOTHER'S MAIDEN NAME Annie Morris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 218-03-2192	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, RIGHT LOWER LOBE 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 6 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 334X		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 31 , 19 57 , to May 16 , 19 57 , when I last saw the deceased and that death occurred at 1:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Chien Wei Lan M.D. VAH, FORT HOWARD, MARYLAND 5/17/57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D. VAH, FORT HOWARD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 20, 1957	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Mortuary, 802-04 Madison Ave.		ADDRESS Baltimore 1, Md.	
24a. REC'D BY REGISTRAR DATE 5/21/57		24b. REGISTRAR'S SIGNATURE Dr. James Farley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
John A. Smith		10/15/1915		Male		White		Married		Teacher		Heart Disease		Home		10/21/1957		10:30 PM		J. A. Smith		J. A. Smith	
Address		City		County		State		Country		Date of Birth		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death	
1011 N. 4th Avenue Street		Baltimore		Anne Arundel		Maryland		United States		10/15/1915		10/21/1957		10:30 PM		J. A. Smith		J. A. Smith		10/21/1957		10:30 PM	
Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death	
Heart Disease		Home		10/21/1957		10:30 PM		J. A. Smith		J. A. Smith		10/21/1957		10:30 PM		J. A. Smith		J. A. Smith		10/21/1957		10:30 PM	

BUREAU V. 11

NOV 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04938

4962

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3yr9m11d</u>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whiteford, Maryland</u>		12X0-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>Route #1 - Whiteford</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Marshall</u> Middle <u>Morris</u> Last <u>Morris</u>		4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>19 57</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>unknown</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>63</u> Days <u>7</u> Hours <u>1</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>63</u> Days <u>7</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>steel worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>steel mills</u>		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Peter Morris</u>		14. MOTHER'S MAIDEN NAME <u>Bebeca</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterioscler. Cardio Vasc. Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized and severe</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Feb. 17</u> , 19 <u>57</u> , to <u>May 24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 24</u> , 19 <u>57</u> , and that death occurred at <u>1:00</u> PM, from the causes and on the date stated above.				
ACTUAL SIGNATURE <u>Stella Wachslar</u>		DATE SIGNED <u>SPRING GROVE STATE HOSPITAL</u>		
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		<u>Catonsville 28, Maryland</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 27, 1957</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>TABERNACLE</u>		22d. LOCATION (City, town, or county) (State) <u>WHITEFORD, MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Harkins, Delta, Pa.</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 27 '57</u>		
24b. REGISTRAR'S SIGNATURE <u>W. H. Harkins</u>				

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		Male		35		May 22, 1922		Memphis, Tennessee		Minister		Shot while fleeing from justice		London, England		10:15 AM		[Signature]	
11. MARITAL STATUS		12. EDUCATION		13. RELIGION		14. PREVIOUS MARRIAGES		15. DATE OF DEATH		16. TIME OF DEATH		17. PLACE OF DEATH		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS	
Single		High School		Methodist		None		May 23, 1968		10:15 AM		London, England		[Signature]		[Signature]		[Signature]	
21. PLACE OF BURIAL		22. NAME OF BURIAL PLACE		23. NAME OF MINISTER		24. NAME OF WITNESS		25. NAME OF WITNESS		26. NAME OF WITNESS		27. NAME OF WITNESS		28. NAME OF WITNESS		29. NAME OF WITNESS		30. NAME OF WITNESS	
St. Martin's Church		St. Martin's Church		St. Martin's Church		St. Martin's Church		St. Martin's Church		St. Martin's Church		St. Martin's Church		St. Martin's Church		St. Martin's Church		St. Martin's Church	

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MAY 27 1968
BUREAU V. 2

4963

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 59 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 107 W. Lee Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARLIN Middle D. Last O'DELL				4. DATE OF DEATH May Month 14 Day 19 Year 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 26, 1897	
9. AGE (In years last birthday) 59		10. IF UNDER 1 YEAR Months 59		11. IF UNDER 24 HRS. Days 59		12. IF UNDER 1 YEAR Hours 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant				10b. KIND OF BUSINESS OR INDUSTRY Gas Filling Sta.		11. BIRTHPLACE (State or foreign country) Mansfield, Pennsylvania	
13. FATHER'S NAME Oscar O'Dell				14. MOTHER'S MAIDEN NAME Ella Sheppard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) Yes				16. SOCIAL SECURITY NO. 070-03-9308		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AORTIC STENOSIS DUE TO 411X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) OLD RHEUMATIC ENDOCARDITIS DUE TO (c) UNKNOWN						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. VA 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 16 , 19 57 , to May 14 , 19 57 , and that death occurred at 11:00 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND				DATE SIGNED 5/14/57			
ACTUAL SIGNATURE Chien Wei Lan				M.D. VAH, FORT HOWARD, MARYLAND			
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.				ADDRESS VAH, FORT HOWARD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-17-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14,				24a. REC'D BY REGISTRAR 5/16/57		24b. REGISTRAR'S SIGNATURE Dr. Dawson L. Farber	

1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4961

CERTIFICATE OF DEATH

04940

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u> 3101.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>308 S. Taylor Ave</u>		d. STREET ADDRESS <u>2105 E. Balto. St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Elena</u> Middle <u>H.</u> Last <u>Ojason</u>		4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 12, 1879</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Latvia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Alfred Ojason</u>		Address <u>308 S. Taylor Ave 21</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC HEART</u> DUE TO <u>DISEASE</u> (c) <u>1 YR.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/29/57</u> 19, to <u>5/30/57</u> 19, that I last saw the deceased alive on <u>5/29/57</u> , 19, and that death occurred at <u>8:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>108 S. TAYLOR</u> DATE SIGNED <u>5/30/57</u>			
ACTUAL SIGNATURE <u>Joseph Nyeck</u> M.D.		PHYSICIAN'S NAME (Type) <u>JOSEPH NIECKI, MD</u> <u>ESSEX 21, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>June 1-57</u>	<u>St. Andrews Cem</u>	<u>Balto. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith Luckey</u>		24. REC'D BY REGISTRAR <u>June 3 1957</u>	
ADDRESS <u>1800 E. Lombard</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Luckey</u>	

BUREAU V. S.

JUN 3 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4965

CERTIFICATE OF DEATH

Reg. Dist. No.

04941

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2yr11mth7dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 Vol-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 410 Mt. Holly Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Josephine Last Otto				4. DATE OF DEATH Month May Day 3 Year 19 57					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 13, 1884			
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nurse				10b. KIND OF BUSINESS OR INDUSTRY NURSING		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U. S. A.									
13. FATHER'S NAME unknown MATTHEW O'BRIEN				14. MOTHER'S MAIDEN NAME unknown JULIA MURPHY					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac failure DUE TO (c) Arteriosclerotic cardiovascular disease								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized and severe								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) SPRING GROVE STATE HOSPITAL				20g. (County)		20h. (State)			
21. I certify that I attended the deceased from March 7, 19 57 , to May 3, 19 57 , that I last saw the deceased alive on May 3, 19 57 , and that death occurred at 9:05 a.m. , from the causes and on the date stated above.									
ACTUAL SIGNATURE Stella Wachsler				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL				DATE SIGNED 5-3-57	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5-4-57		22c. NAME OF CEMETERY OR CREMATORY CATHEDRAL CEM.		22d. LOCATION (City, town, or county) (State) Bald. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Fairley Funeral Home Catonsville #28MD				ADDRESS Catonsville #28MD		24a. REC'D BY REGISTRAR DATE MAY 6 57		24b. REGISTRAR'S SIGNATURE Robt. [unclear]	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Illegible Name]</p>		<p>2. SEX [Illegible]</p>		<p>3. AGE [Illegible]</p>	
<p>4. DATE OF DEATH [Illegible]</p>		<p>5. TIME OF DEATH [Illegible]</p>		<p>6. PLACE OF DEATH [Illegible]</p>	
<p>7. CAUSE OF DEATH [Illegible]</p>		<p>8. MANNER OF DEATH [Illegible]</p>		<p>9. PLACE OF BIRTH [Illegible]</p>	
<p>10. DATE OF BIRTH [Illegible]</p>		<p>11. TIME OF BIRTH [Illegible]</p>		<p>12. PLACE OF BIRTH [Illegible]</p>	
<p>13. NAME OF PHYSICIAN [Illegible]</p>		<p>14. NAME OF CLERGYPERSON [Illegible]</p>		<p>15. NAME OF REGISTRAR [Illegible]</p>	
<p>16. NAME OF WITNESS [Illegible]</p>		<p>17. NAME OF WITNESS [Illegible]</p>		<p>18. NAME OF WITNESS [Illegible]</p>	
<p>19. NAME OF WITNESS [Illegible]</p>		<p>20. NAME OF WITNESS [Illegible]</p>		<p>21. NAME OF WITNESS [Illegible]</p>	
<p>22. NAME OF WITNESS [Illegible]</p>		<p>23. NAME OF WITNESS [Illegible]</p>		<p>24. NAME OF WITNESS [Illegible]</p>	
<p>25. NAME OF WITNESS [Illegible]</p>		<p>26. NAME OF WITNESS [Illegible]</p>		<p>27. NAME OF WITNESS [Illegible]</p>	
<p>28. NAME OF WITNESS [Illegible]</p>		<p>29. NAME OF WITNESS [Illegible]</p>		<p>30. NAME OF WITNESS [Illegible]</p>	
<p>31. NAME OF WITNESS [Illegible]</p>		<p>32. NAME OF WITNESS [Illegible]</p>		<p>33. NAME OF WITNESS [Illegible]</p>	
<p>34. NAME OF WITNESS [Illegible]</p>		<p>35. NAME OF WITNESS [Illegible]</p>		<p>36. NAME OF WITNESS [Illegible]</p>	
<p>37. NAME OF WITNESS [Illegible]</p>		<p>38. NAME OF WITNESS [Illegible]</p>		<p>39. NAME OF WITNESS [Illegible]</p>	
<p>40. NAME OF WITNESS [Illegible]</p>		<p>41. NAME OF WITNESS [Illegible]</p>		<p>42. NAME OF WITNESS [Illegible]</p>	
<p>43. NAME OF WITNESS [Illegible]</p>		<p>44. NAME OF WITNESS [Illegible]</p>		<p>45. NAME OF WITNESS [Illegible]</p>	
<p>46. NAME OF WITNESS [Illegible]</p>		<p>47. NAME OF WITNESS [Illegible]</p>		<p>48. NAME OF WITNESS [Illegible]</p>	
<p>49. NAME OF WITNESS [Illegible]</p>		<p>50. NAME OF WITNESS [Illegible]</p>		<p>51. NAME OF WITNESS [Illegible]</p>	
<p>52. NAME OF WITNESS [Illegible]</p>		<p>53. NAME OF WITNESS [Illegible]</p>		<p>54. NAME OF WITNESS [Illegible]</p>	
<p>55. NAME OF WITNESS [Illegible]</p>		<p>56. NAME OF WITNESS [Illegible]</p>		<p>57. NAME OF WITNESS [Illegible]</p>	
<p>58. NAME OF WITNESS [Illegible]</p>		<p>59. NAME OF WITNESS [Illegible]</p>		<p>60. NAME OF WITNESS [Illegible]</p>	
<p>61. NAME OF WITNESS [Illegible]</p>		<p>62. NAME OF WITNESS [Illegible]</p>		<p>63. NAME OF WITNESS [Illegible]</p>	
<p>64. NAME OF WITNESS [Illegible]</p>		<p>65. NAME OF WITNESS [Illegible]</p>		<p>66. NAME OF WITNESS [Illegible]</p>	
<p>67. NAME OF WITNESS [Illegible]</p>		<p>68. NAME OF WITNESS [Illegible]</p>		<p>69. NAME OF WITNESS [Illegible]</p>	
<p>70. NAME OF WITNESS [Illegible]</p>		<p>71. NAME OF WITNESS [Illegible]</p>		<p>72. NAME OF WITNESS [Illegible]</p>	
<p>73. NAME OF WITNESS [Illegible]</p>		<p>74. NAME OF WITNESS [Illegible]</p>		<p>75. NAME OF WITNESS [Illegible]</p>	
<p>76. NAME OF WITNESS [Illegible]</p>		<p>77. NAME OF WITNESS [Illegible]</p>		<p>78. NAME OF WITNESS [Illegible]</p>	
<p>79. NAME OF WITNESS [Illegible]</p>		<p>80. NAME OF WITNESS [Illegible]</p>		<p>81. NAME OF WITNESS [Illegible]</p>	
<p>82. NAME OF WITNESS [Illegible]</p>		<p>83. NAME OF WITNESS [Illegible]</p>		<p>84. NAME OF WITNESS [Illegible]</p>	
<p>85. NAME OF WITNESS [Illegible]</p>		<p>86. NAME OF WITNESS [Illegible]</p>		<p>87. NAME OF WITNESS [Illegible]</p>	
<p>88. NAME OF WITNESS [Illegible]</p>		<p>89. NAME OF WITNESS [Illegible]</p>		<p>90. NAME OF WITNESS [Illegible]</p>	
<p>91. NAME OF WITNESS [Illegible]</p>		<p>92. NAME OF WITNESS [Illegible]</p>		<p>93. NAME OF WITNESS [Illegible]</p>	
<p>94. NAME OF WITNESS [Illegible]</p>		<p>95. NAME OF WITNESS [Illegible]</p>		<p>96. NAME OF WITNESS [Illegible]</p>	
<p>97. NAME OF WITNESS [Illegible]</p>		<p>98. NAME OF WITNESS [Illegible]</p>		<p>99. NAME OF WITNESS [Illegible]</p>	
<p>100. NAME OF WITNESS [Illegible]</p>		<p>101. NAME OF WITNESS [Illegible]</p>		<p>102. NAME OF WITNESS [Illegible]</p>	

BUREAU V. 2

MAY 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4848

CERTIFICATE OF DEATH

04942

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. LENGTH OF STAY IN 1b <u>37</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>52 TOWNSHIP</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HILDA</u> Middle <u>GRIFFITHS</u> Last <u>OWENS</u>				4. DATE OF DEATH Month <u>5</u> - Day <u>23</u> - Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 26, 1882</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Mins. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Mins. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WALES</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>EDWIN GRIFFITHS</u>				14. MOTHER'S MAIDEN NAME <u>SARA GRIFFIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>JOHN E. OWENS - SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A-S-C-U-Disease</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>5 yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5-21</u> , 19 <u>57</u> , to <u>5-23</u> , 19 <u>57</u> that I last saw the deceased alive on <u>5-21</u> , 19 <u>57</u> , and that death occurred at <u>1300</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M B Davis</u> M.D.				ADDRESS (Street, city or town, state) <u>6800 MORNINGSTAR RD</u>			
PHYSICIAN'S NAME (Type) <u>M B DAVIS M.D.</u>				DATE SIGNED <u>5-27-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ODOR LANN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Berke Bradley, Dundalk, Md.</u>				24a. REC'D BY REGISTRAR <u>MAY 27 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>							

CERTIFICATE OF DEATH

[Faint, mostly illegible text from the reverse side of the document is visible through the paper. Discernible words include:]

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
DATE OF BIRTH
SEX
RACE
RELIGION
EDUCATION
OCCUPATION
RESIDENCE
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
DATE OF BIRTH
SEX
RACE
RELIGION
EDUCATION
OCCUPATION
RESIDENCE

BUREAU V. 3

MAY 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04943

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b ----			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>301 Lennox Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE</u> <u>PARKER</u>				4. DATE OF DEATH Month Day Year <u>May 17</u> <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 22, 1880</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 MRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cleaning plant</u>		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Wilson Parker</u>				14. MOTHER'S MAIDEN NAME <u>Lucinda</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mr. Shelton Parker</u> <u>301 Lennox Ave.</u> <u>Towson, Maryland</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO <u>1 Hr.</u> (c) <u>15 yrs.</u></p> </div> <div style="width: 50%;"> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u></p> </div> </div>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>				DATE SIGNED <u>5/18/57</u>			
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 21, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant rest</u>		22d. LOCATION (City, town, or county) (State) <u>Towson, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Funerals Home</u> <u>1631 Druid Hill Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>5/22/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mable Gray</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

BUREAU V. 8

MAY 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4967

CERTIFICATE OF DEATH

04944

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7100 W. Bellona Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle THOMAS Last PARKER		4. DATE OF DEATH Month May Day 8 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1893
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Contractor		9b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	9c. AGE (In years last birthday) 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Contractor		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	10c. CITIZEN OF WHAT COUNTRY? USA
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John M. Parker		14. MOTHER'S MAIDEN NAME Katherine Kreamer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-18-4217	
17. INFORMANT Mrs. Marjorie B. Parker		Address 7100 W. Bellona	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension cardiovascular renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral hemorrhage with hemiplegia (left) DUE TO (c) Cerebral hemorrhage with hemiplegia (right)			INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 1 yr. 12 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December , 19 51 , to May 8 , 19 57 , that I last saw the deceased alive on May 8 , 19 57 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3900 York Road Baltimore DATE SIGNED 5/9/57			
ACTUAL SIGNATURE Lloyd E. Saylor M.D.		DATE SIGNED 5/9/57	
PHYSICIAN'S NAME (Type) Dr. Lloyd Saylor		ADDRESS 3900 York Road Baltimore	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF May 11, 1957	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. SANDER & SONS, INC.		24a. REC'D BY REGISTRAR 5/13/57	
ADDRESS Baltimore, Md.		24b. REGISTRAR'S SIGNATURE Mabel Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

1957 31 12

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04945
23

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Owings Mills		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Amon Last Pettie		4. DATE OF DEATH Month May Day 2 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1887
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 69 Days 00 Hours 00 Min. 00	IF UNDER 24 HRS. Months 00 Days 00 Hours 00 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman		10b. KIND OF BUSINESS OR INDUSTRY Baltio. Transit	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Walker Pettie		14. MOTHER'S MAIDEN NAME Emma Hitt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-09-3673	
17. INFORMANT Mrs. Agnes Pettie		Address Owings Mills, Md. 11019 Reisterstown Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) none DUE TO (c) none PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE D. D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 6, 1957	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Pikesville, Md.		24a. REC'D BY REGISTRAR MAY 6 1957	
		24b. REGISTRAR'S SIGNATURE Mary Eliza	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11.7

BUREAU V. 3.

MAY 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04946

CERTIFICATE OF DEATH

Reg. Dist. No.

37

4969

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4109 Priscilla Lane</u>				d. STREET ADDRESS <u>4109 Priscilla Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>PODOBSKY</u> Last				4. DATE OF DEATH Month <u>5</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>68</u> yrs.	
9. AGE (In years last birthday) <u>68</u> yrs.				IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Nathan</u>			
14. MOTHER'S MAIDEN NAME <u>Not known</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Daniel Ginsberg - same</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Cardio Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 15, 1950</u> , to <u>May 8, 1957</u> , that I last saw the deceased alive on <u>May 8, 1957</u> , and that death occurred at <u>320 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Albert J. HimelefARB</u>				ADDRESS (Street, city or town, state) <u>3501 St. Paul St. Balto - Md.</u>			
DATE SIGNED <u>5/9/57</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>5-9-57</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>				22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc</u>				24a. REC'D BY REGISTRAR <u>2100 Eutaw Pl</u>			
24b. REGISTRAR'S SIGNATURE <u>Donny Nench</u>				DATE <u>5/10/57</u>			

2000

BUREAU V. S.

MAY 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4970

CERTIFICATE OF DEATH

04947

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belair, Md. 12 x 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS Belair General Delivery	
3. NAME OF DECEASED (Type or print) First Russell Middle McKinley Last Pritt		4. DATE OF DEATH Month May Day 10 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1896
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Romey Pritt		14. MOTHER'S MAIDEN NAME Malveste Cutlitt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from February 29, 1956 , to May 10, 1957 , that I last saw the deceased alive on May 10, 1957 , and that death occurred at 9:25 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles Ward</i>		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Charles Ward, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 5-13-57	22c. NAME OF CEMETERY OR CREMATORY Belair Memorial	22d. LOCATION (City, town, or county) (State) Belair Harford Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Martin Skutumpah</i>		24a. REC'D BY REGISTRAR DATE MAY 14 '57	
ADDRESS <i>Janettable</i>		24b. REGISTRAR'S SIGNATURE <i>Al. Lewis</i>	

BUREAU V. 21

1957 14

RECEIVED

Maria Theresia

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 2 Film 6216 6-10-57 et
CERTIFICATE OF DEATH

04948

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2yr2mth2dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Quail				4. DATE OF DEATH Month May Day 24 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown	
9. AGE (In years last birthday) 86 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ireland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME UNKNOWN			
14. MOTHER'S MAIDEN NAME Delphenia				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. unknown				17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary infarction DUE TO (c) Hypertensive cardiovascular disease							INTERVAL BETWEEN ONSET AND DEATH two years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) SPRING GROVE STATE HOSPITAL				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from March 22, 1955 , to May 24, 1957 , that I last saw the deceased alive on May 24, 1957 , and that death occurred at 4:50a M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslor				M.D. SPRING GROVE STATE HOSPITAL			
PHYSICIAN'S NAME (Type) Stella Wachslor, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/28/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Catonsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley Funeral Home				ADDRESS Mt. Rainier		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE Quail				24c. DATE May 27 57			

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MAY 27 1957
BUREAU V. 1

MAY 27 1957

4972

CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cub Hill</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X2 Cub Hill</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>10013 Harford Road</i>		d. STREET ADDRESS <i>1 10013 Harford Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Mr. Emmitt H.</i> Middle <i>Richards</i> Last		4. DATE OF DEATH Month <i>May</i> Day <i>25th</i> Year <i>19 57</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 11, 1880</i>
9. AGE (In years last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Store Owner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Richards</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Plgire</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Minnie A. Richards</i>		Address <i>10013 Harford Road</i>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Colon, with general</i> <i>153X</i> DUE TO <i>Metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>420. Coronary Sclerosis, generalized arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <i>1955</i> to <i>5/25</i> , <i>1957</i> , that I last saw the deceased alive on <i>May 25</i> , <i>1957</i> , and that death occurred at <i>2:00</i> P.M., from the causes and on the date stated above.		21a. ADDRESS (Street, city or town, state) <i>6010 York Road</i>	21b. DATE SIGNED <i>5/25/57</i>
ACTUAL SIGNATURE <i>Louis N. Rudin</i> M.D.			
PHYSICIAN'S NAME (Type) <i>Dr. Louis N. Rudin</i>			

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5/29/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road.</i>	24a. REC'D BY REGISTRAR <i>MAY 28 1957</i>
		24b. REGISTRAR'S SIGNATURE <i>L. H. M. Brown</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. 2

MAY 28 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4973

CERTIFICATE OF DEATH

Reg. Dist. No.

04950

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3101.4					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Catonsville Convalescent Home				d. STREET ADDRESS 5608 Greenhill Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First NATHANIEL Middle Last RICHARDSON				4. DATE OF DEATH Month May Day 19 Year 57					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 3 1876			
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber				10b. KIND OF BUSINESS OR INDUSTRY May Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Richardson				14. MOTHER'S MAIDEN NAME Rebecca Brice					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-05-6952		17. INFORMANT Address Mrs. Thelma Pool - 5208 Gwynndale Ave.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO ASCVD Disease Severe (c) Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH 15 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-3 , 19 57 , to 5-19 , 19 57 , that I last saw the deceased alive on 5-17 , 19 57 , and that death occurred at 100 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 908 Frederick Rd. Catonsville Md. DATE SIGNED 5-20-57 ACTUAL SIGNATURE Stephen Lee Magness M.D. PHYSICIAN'S NAME (Type) STEPHEN LEE MAGNESS									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/23/1957		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost ADDRESS 4600 Liberty Hights.				24a. REC'D BY REGISTRAR DATE MAY 21 '57		24b. REGISTRAR'S SIGNATURE Ellsworth			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. B.

MAY 21 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04951

4974

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 224 Hopkins Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marie Middle Taylor Last Rix		4. DATE OF DEATH Month May Day 16 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-3-1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	11. IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Taylor		14. MOTHER'S MAIDEN NAME Sarah ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles G. Preston, 102 Murdock Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Departure Cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sporadic Depression			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 10 , 19 57 , to May 16 , 19 57 , that I last saw the deceased alive on May 13 , 19 57 , and that death occurred at 6:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William J. Schmitz		DATE SIGNED May 16 1957	
PHYSICIAN'S NAME (Type) William J. Schmitz		M.D. John R. Kennedy	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-20-1957	
22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons Co., Inc.		24a. REC'D BY REGISTRAR DATE 5/20/57	
24b. REGISTRAR'S SIGNATURE Mabel Gray			

BUREAU V

MAY 20 1957

RECEIVED

4975

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 31 3401.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor Nursing Home		d. STREET ADDRESS 536 S. Ann St.	
3. NAME OF DECEASED (Type or print) First MARTIN Middle Last ROWLENS		4. DATE OF DEATH Month May Day 24 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10. 1881
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Bohemia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Rowlens		14. MOTHER'S MAIDEN NAME Bertha Lawrence	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT James Rowlens (son)		Address 536 S. Ann St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 33/X DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE William F. Fritz		ADDRESS (Street, city or town, state) 241 University Park DATE SIGNED 5/24/57	
PHYSICIAN'S NAME (Type) William F. Fritz, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 27. 1957	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery Baltimore Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC. Baltimore Md.		24a. REC'D BY REGISTRAR DATE MAY 27 57	
24b. REGISTRAR'S SIGNATURE Barth Sander			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MAY 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4976 CERTIFICATE OF DEATH

04953
33

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b Baltimore 18, Md. 3701-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 22 Walston		d. STREET ADDRESS 3621 Old York Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Etha B. Russell		4. DATE OF DEATH Month May Day 10 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1873
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Standish M. Berryman		14. MOTHER'S MAIDEN NAME Ely. Warner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Stuart B. Russell, Baltimore, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C-V Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from Oct. 14, 1955 , to May 10, 1957 , that I last saw the deceased alive on May 8, 1957 , and that death occurred at 9 A M , from the causes and on the date stated above.			
ACTUAL SIGNATURE D. D. Caples		ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 5-13-57	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 13, 57	22c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery	
22d. LOCATION (City, town, or county) (State) Reisterstown, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J.F.Eline & Sons Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE 5-12-57	
24b. REGISTRAR'S SIGNATURE Mary B. Eline			

CERTIFICATE OF DEATH

4332

DEPARTMENT OF HEALTH - BALTIMORE 18 4332		BALTIMORE	
NAME OF DECEASED ELIZABETH		RELATIONSHIP DAUGHTER	
SEX FEMALE		AGE 38 YEARS	
DATE OF DEATH MAY 15, 1957		PLACE OF DEATH HOME	
TIME OF DEATH 11:00 AM		CAUSE OF DEATH HEART DISEASE	
PLACE OF BIRTH NEW YORK		PLACE OF DEATH BALTIMORE	
NAME OF DECEASED ELIZABETH		RELATIONSHIP DAUGHTER	
SEX FEMALE		AGE 38 YEARS	
DATE OF DEATH MAY 15, 1957		PLACE OF DEATH HOME	
TIME OF DEATH 11:00 AM		CAUSE OF DEATH HEART DISEASE	
PLACE OF BIRTH NEW YORK		PLACE OF DEATH BALTIMORE	

BUREAU V. 2

MAY 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04954

4977

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		d. STREET ADDRESS <u>Cockeysville Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Savard</u> Last <u>Savard</u>		4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1278</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u> Hours <u>15</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Unknown - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Ida Joyce</u> Address <u>Cockeysville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>noted</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 28, 1956</u> to <u>May 4, 1957</u> , that I last saw the deceased alive on <u>May 4, 1957</u> , and that death occurred at <u>12 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gertrude J. Fleishman</u> M.D.		DATE SIGNED _____	
PHYSICIAN'S NAME (Type) <u>GERTRUDE J. FLEISHMAN</u>		ADDRESS (Street, city or town, state) <u>Spring Grove State Hospital, Catonsville 28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>May 7, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOSEPH'S CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>TEXAS, BALTO CO, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John P. Jones, Towson, Md.</u> ADDRESS _____		24a. REC'D BY REGISTRAR <u>May 7 '57</u> 24b. REGISTRAR'S SIGNATURE <u>W. H. Jones</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John William Smith</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 14 1912</i>	
5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Engineer</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>June 15 1938</i>	
9. NAME OF SPOUSE <i>Elizabeth Smith</i>		10. DATE OF DEATH <i>May 2 1957</i>	
11. PLACE OF DEATH <i>Home</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. MEDICAL HISTORY <i>None</i>		14. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
15. SIGNATURE OF REGISTRAR <i>[Signature]</i>		16. OFFICIAL USE	

RECEIVED
MAY 7 1957
BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4978

CERTIFICATE OF DEATH

Reg. Dist. No. 38

04955

1. PLACE OF DEATH a. COUNTY <u>BALTO. CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A. A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). <u>Cockeysville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rest home</u>				d. STREET ADDRESS <u>02X0.2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Sarah V. Sawyer</u>				4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/17/1870</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas Berry</u>				14. MOTHER'S MAIDEN NAME <u>Munnally</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Edgar T. Sawyer Catonsville</u>			
17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 10</u> , 19 <u>57</u> , to <u>May 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 12</u> , 19 <u>57</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Frank Supplee, III</u>				DATE SIGNED <u>1014 ST Paul ST, Balt 2, Md</u>			
PHYSICIAN'S NAME (Type) <u>J. Frank Supplee, III</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>A. A. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Nabbs Son Catonsville</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>5/14/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Shabel Gray</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for death certificate, including fields for name, date, cause of death, and signature. The form is filled out with handwritten information.

NAME: *John Doe*
DATE: *10/15/57*
CAUSE OF DEATH: *Heart Disease*
SIGNATURE: *John Doe*

BUREAU W. M.

AY 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12 Film 0217 7-2-57 et

4979

CERTIFICATE OF DEATH

04956

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Beth.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7907 Ivy Lane</u>		d. STREET ADDRESS <u>7907 Ivy Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>SCHAPIRO</u> Last <u>RO</u>		4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 25, 1896</u>
9. AGE (In years lost birthday) <u>60</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNKNOWN</u>	
13. FATHER'S NAME <u>Solomon Schapiro</u>		14. MOTHER'S MAIDEN NAME <u>Betha</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>Marvin Schapiro - same</u>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease with complete heart block</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)

21. I certify that I attended the deceased from <u>Dec 15</u> , 19 <u>56</u> to <u>18 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>15 May</u> , 19 <u>57</u> , and that death occurred at <u>10:42</u> A.M., from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Paul H Royse</u> M.D. <u>908 Reisterstown Rd</u>	DATE SIGNED <u>18 May 57</u>
PHYSICIAN'S NAME (Type) <u>Paul H Royse M.D.</u> <u>Pikesville 9 ind.</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 20/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Beth Tphok Cong</u>	22d. LOCATION (City, town, or county) (State) <u>Beth Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Levenson & Bros Inc</u> ADDRESS <u>1124-26 ave</u>		24a. REC'D BY REGISTRAR DATE <u>5/21/57</u>	24b. REGISTRAR'S SIGNATURE <u>Wm J. Kelly</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1-3 should be filed with the register for to burial, cremation, or removal, and in any event within 72 hours after death.

JAY 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

4980

Reg. Dist. No.

04957

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle H Last SCHNEIDER				4. DATE OF DEATH Month MAY Day 12 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-8-96	
9. AGE (In years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH A. SCHNEIDER				14. MOTHER'S MAIDEN NAME MARGARET HENSY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 212-07-3241		17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GANGRENE OF INTESTINES 570.2 DUE TO (b) PERITONITIS, GENERALIZED DUE TO (c) MESENTERY VENOUS THROMBOSIS CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 578x							INTERVAL BETWEEN ONSET AND DEATH FEW DAYS FEW DAYS FEW DAYS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 10, 19 57 , to May 12, 19 57 , and that death occurred at 5:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 5/13/57 ACTUAL SIGNATURE Chien Wei Lan M.D. VAH, FORT HOWARD, MARYLAND PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D. VAH, FORT HOWARD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/16/57		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, 2601 E. Madison St. Balto. Md.				24a. REC'D BY REGISTRAR 5/15/57		24b. REGISTRAR'S SIGNATURE Dr. Dawson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH		PLACE OF DEATH	
JOHN J. JONES		MALE		35		JAN 15 1957		BALTIMORE, MARYLAND	
MOTHER'S NAME		FATHER'S NAME		MARRIAGE DATE		MARRIAGE PLACE		MARRIAGE REGISTRATION NO.	
MARY J. JONES		JOHN J. JONES		JAN 15 1950		BALTIMORE, MARYLAND		123456789	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		CATHOLIC	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		DATE OF BURIAL	
JAN 15 1922		BALTIMORE, MARYLAND		JAN 15 1957		BALTIMORE, MARYLAND		JAN 16 1957	
DATE OF DEATH		PLACE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		DATE OF INTERMENT	
JAN 15 1957		BALTIMORE, MARYLAND		JAN 16 1957		BALTIMORE, MARYLAND		JAN 16 1957	

BUREAU V. 21

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04958

4981

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>22yr3mtn15dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>F.</u> Last <u>Schreibke</u>		4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1912</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>44</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>GEORGE Schreibke</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Kraubs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>6to10-1932</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 9</u> , 19 <u>57</u> , to <u>May 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 18</u> , 19 <u>57</u> , and that death occurred at <u>9:30aM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL</u> <u>5-20-57</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		<u>Catonsville, 28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/21/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>MAY 22 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

CERTIFICATE OF DEATH

REG. DIR. NO.

PLACE OF BIRTH		PLACE OF DEATH	
CITY OF BALTIMORE		CITY OF BALTIMORE	
COUNTY OF BALTIMORE		COUNTY OF BALTIMORE	
DATE OF BIRTH		DATE OF DEATH	
MAY 18 1957		MAY 18 1957	
TIME OF BIRTH		TIME OF DEATH	
12:00 PM		12:00 PM	
AGE		AGE	
18		18	
SEX		SEX	
Male		Male	
RACE		RACE	
White		White	
EDUCATION		EDUCATION	
High School		High School	
OCCUPATION		OCCUPATION	
Student		Student	
CAUSE OF DEATH		CAUSE OF DEATH	
Heart Disease		Heart Disease	
Manner of Death		Manner of Death	
Natural		Natural	
Signature of Physician		Signature of Physician	
[Signature]		[Signature]	
Signature of Registrar		Signature of Registrar	
[Signature]		[Signature]	

BUREAU V. B.

MAY 23 1957

RECEIVED

4982
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1108 Litchfield Rd.		d. STREET ADDRESS 1108 Litchfield Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LOUIS W. SCHROTH		4. DATE OF DEATH Month Day Year May 3, 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired helper truck		10b. KIND OF BUSINESS OR INDUSTRY Rugs	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Schroth		14. MOTHER'S MAIDEN NAME Mary Weil	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Irene Burton - 1108 Litchfield Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBACUTE MYOCARDIAL DEGENERATION. 431X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. No 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) No	
21. I certify that I attended the deceased from JUNE, 1956 , 19____, to MAY, 3, 1957 , that I last saw the deceased alive on May, 2, 1957 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6348 FREDERICK ROAD CATONVILLE MD			
ACTUAL SIGNATURE <i>S. Lloyd Johnson</i>		M.D. 6348 FREDERICK ROAD CATONVILLE MD	
PHYSICIAN'S NAME (Type) S. LLOYD JOHNSON, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/7/57	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Lickner & Sons - Balto.</i>		24a. REC'D BY REGISTRAR MAY 7 '57	
ADDRESS Balto., Md.		24b. REGISTRAR'S SIGNATURE <i>DeL...</i>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 77 hours after death.

BUREAU V. S.

MAY 8 1957

RECEIVED

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>		LENGTH OF STAY (in this place) <u>2 WEEKS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Balto</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in Pines</u>				STREET ADDRESS <u>3806 Glenzyle Ave</u>	
3. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH	
<u>LOTTIE</u>		<u>SCHWARTZ</u>		<u>May 20 1957</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months Days Hours Min.
<u>Female</u>	<u>White</u>	<u>Widow</u>		<u>67</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY
<u>Housewife</u>			<u>New York</u>		<u>USA</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
<u>Jacob Singer</u>		<u>Leah</u>			
15. Was DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS		
			<u>Melvin Monfort - 6722 Pimlico Rd.</u>		
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>CORONARY OCCLUSION</u>					<u>20 Minute</u>
Antecedent cause(s) (b) <u>ELECTROSHOCK THERAPY</u>					<u>1 Hour</u>
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>					<u>YEARS</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
<u>955X</u>				Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 7</u> , 19 <u>57</u> , to <u>May 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 20</u> , 19 <u>57</u> , and that death occurred at <u>1:25 p.m.</u> , from the causes and on the date stated above.					
SIGNATURE		(Degree or title)		DATE SIGNED	
<u>Edward F. Kerman M.D.</u>		<u>3700 Reberly Heights Ave</u>		<u>7/20/57</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>5-22-1957</u>		<u>Balto Helix</u>	
LOCATION (City, town, or county)		(State)			
<u>Balto Md.</u>					
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>5/21/57</u>		<u>Chas. H. Kersch</u>		<u>Frank Lewis Inc - 2100 Eutan Rd.</u>	

BUREAU V. S.

APR 23 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04961

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where Deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore #12</u>		c. LENGTH OF STAY IN 1b <u>21 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>251 Stanmore Rd.</u>		d. STREET ADDRESS <u>1251 Stanmore Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>Scott</u> Last <u>Scott</u>		4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 13/1893</u>
9. AGE (In years last birthday) <u>64 yrs.</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u>6</u> Min. <u>4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State College</u>	
11. BIRTHPLACE (State or foreign country) <u>Madonia Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Cal Scott</u>		14. MOTHER'S MAIDEN NAME <u>Laura Stafford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-36-2404</u>	
17. INFORMANT <u>Miss Elizabeth Scott</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>MAY 14/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>4905 York Rd</u>		22d. LOCATION (City, town, or county) (State) <u>LADONIA TEXAS</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Berry N. Jenkins</u>		24a. REC'D BY REGISTRAR <u>DATE 5/14/57</u>	
ADDRESS <u>4905 York Rd</u>		24b. REGISTRAR'S SIGNATURE <u>R. A. M. Bacon</u>	

DATE SIGNED 5/12/57

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. OCCUPATION <i>Teacher</i>		5. MARITAL STATUS <i>Married</i>		6. PLACE OF BIRTH <i>Washington, D.C.</i>	
7. DATE OF DEATH <i>May 15, 1957</i>		8. TIME OF DEATH <i>10:30 AM</i>		9. PLACE OF DEATH <i>Home</i>	
10. CAUSE OF DEATH <i>Myocardial Infarction</i>		11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF EXAMINER <i>[Signature]</i>	
13. SIGNATURE OF ATTENDING PHYSICIAN <i>[Signature]</i>		14. SIGNATURE OF CORONER <i>[Signature]</i>		15. SIGNATURE OF WITNESSES <i>[Signature]</i>	
16. SIGNATURE OF DECEASED <i>[Signature]</i>		17. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		18. SIGNATURE OF BURIAL OFFICIAL <i>[Signature]</i>	
19. SIGNATURE OF FUNERAL HOME <i>[Signature]</i>		20. SIGNATURE OF CEMETERY <i>[Signature]</i>		21. SIGNATURE OF CHURCH <i>[Signature]</i>	
22. SIGNATURE OF MINISTRY <i>[Signature]</i>		23. SIGNATURE OF OTHER <i>[Signature]</i>		24. SIGNATURE OF OTHER <i>[Signature]</i>	
25. SIGNATURE OF OTHER <i>[Signature]</i>		26. SIGNATURE OF OTHER <i>[Signature]</i>		27. SIGNATURE OF OTHER <i>[Signature]</i>	
28. SIGNATURE OF OTHER <i>[Signature]</i>		29. SIGNATURE OF OTHER <i>[Signature]</i>		30. SIGNATURE OF OTHER <i>[Signature]</i>	
31. SIGNATURE OF OTHER <i>[Signature]</i>		32. SIGNATURE OF OTHER <i>[Signature]</i>		33. SIGNATURE OF OTHER <i>[Signature]</i>	
34. SIGNATURE OF OTHER <i>[Signature]</i>		35. SIGNATURE OF OTHER <i>[Signature]</i>		36. SIGNATURE OF OTHER <i>[Signature]</i>	
37. SIGNATURE OF OTHER <i>[Signature]</i>		38. SIGNATURE OF OTHER <i>[Signature]</i>		39. SIGNATURE OF OTHER <i>[Signature]</i>	
40. SIGNATURE OF OTHER <i>[Signature]</i>		41. SIGNATURE OF OTHER <i>[Signature]</i>		42. SIGNATURE OF OTHER <i>[Signature]</i>	
43. SIGNATURE OF OTHER <i>[Signature]</i>		44. SIGNATURE OF OTHER <i>[Signature]</i>		45. SIGNATURE OF OTHER <i>[Signature]</i>	
46. SIGNATURE OF OTHER <i>[Signature]</i>		47. SIGNATURE OF OTHER <i>[Signature]</i>		48. SIGNATURE OF OTHER <i>[Signature]</i>	
49. SIGNATURE OF OTHER <i>[Signature]</i>		50. SIGNATURE OF OTHER <i>[Signature]</i>		51. SIGNATURE OF OTHER <i>[Signature]</i>	
52. SIGNATURE OF OTHER <i>[Signature]</i>		53. SIGNATURE OF OTHER <i>[Signature]</i>		54. SIGNATURE OF OTHER <i>[Signature]</i>	
55. SIGNATURE OF OTHER <i>[Signature]</i>		56. SIGNATURE OF OTHER <i>[Signature]</i>		57. SIGNATURE OF OTHER <i>[Signature]</i>	
58. SIGNATURE OF OTHER <i>[Signature]</i>		59. SIGNATURE OF OTHER <i>[Signature]</i>		60. SIGNATURE OF OTHER <i>[Signature]</i>	
61. SIGNATURE OF OTHER <i>[Signature]</i>		62. SIGNATURE OF OTHER <i>[Signature]</i>		63. SIGNATURE OF OTHER <i>[Signature]</i>	
64. SIGNATURE OF OTHER <i>[Signature]</i>		65. SIGNATURE OF OTHER <i>[Signature]</i>		66. SIGNATURE OF OTHER <i>[Signature]</i>	
67. SIGNATURE OF OTHER <i>[Signature]</i>		68. SIGNATURE OF OTHER <i>[Signature]</i>		69. SIGNATURE OF OTHER <i>[Signature]</i>	
70. SIGNATURE OF OTHER <i>[Signature]</i>		71. SIGNATURE OF OTHER <i>[Signature]</i>		72. SIGNATURE OF OTHER <i>[Signature]</i>	
73. SIGNATURE OF OTHER <i>[Signature]</i>		74. SIGNATURE OF OTHER <i>[Signature]</i>		75. SIGNATURE OF OTHER <i>[Signature]</i>	
76. SIGNATURE OF OTHER <i>[Signature]</i>		77. SIGNATURE OF OTHER <i>[Signature]</i>		78. SIGNATURE OF OTHER <i>[Signature]</i>	
79. SIGNATURE OF OTHER <i>[Signature]</i>		80. SIGNATURE OF OTHER <i>[Signature]</i>		81. SIGNATURE OF OTHER <i>[Signature]</i>	
82. SIGNATURE OF OTHER <i>[Signature]</i>		83. SIGNATURE OF OTHER <i>[Signature]</i>		84. SIGNATURE OF OTHER <i>[Signature]</i>	
85. SIGNATURE OF OTHER <i>[Signature]</i>		86. SIGNATURE OF OTHER <i>[Signature]</i>		87. SIGNATURE OF OTHER <i>[Signature]</i>	
88. SIGNATURE OF OTHER <i>[Signature]</i>		89. SIGNATURE OF OTHER <i>[Signature]</i>		90. SIGNATURE OF OTHER <i>[Signature]</i>	
91. SIGNATURE OF OTHER <i>[Signature]</i>		92. SIGNATURE OF OTHER <i>[Signature]</i>		93. SIGNATURE OF OTHER <i>[Signature]</i>	
94. SIGNATURE OF OTHER <i>[Signature]</i>		95. SIGNATURE OF OTHER <i>[Signature]</i>		96. SIGNATURE OF OTHER <i>[Signature]</i>	
97. SIGNATURE OF OTHER <i>[Signature]</i>		98. SIGNATURE OF OTHER <i>[Signature]</i>		99. SIGNATURE OF OTHER <i>[Signature]</i>	
100. SIGNATURE OF OTHER <i>[Signature]</i>		101. SIGNATURE OF OTHER <i>[Signature]</i>		102. SIGNATURE OF OTHER <i>[Signature]</i>	

BUREAU V. 41
MAY 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4855 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04962

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus Halethrope	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1652 Sulphur Spring Rd		d. STREET ADDRESS 1652 Sulphur Spring Rd	
3. NAME OF DECEASED (Type or print) First Middle Last Earl P. Secrist		4. DATE OF DEATH Month Day Year May 5 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8. 1894
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Worker		10b. KIND OF BUSINESS OR INDUSTRY Apple orchard	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S. A	
13. FATHER'S NAME George Secrist		14. MOTHER'S MAIDEN NAME Hattie ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 220-09-3638	
17. INFORMANT Mrs. Frances Brook		Address 1652 Sulphur Spring Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Geo. S. M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF May 5, 1957	
22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cem. Woodbine Cemetery		22d. LOCATION (City, town, or county) (State) Rockingham Co. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.		ADDRESS 1217 St. Paul Street	
24a. REC'D BY REGISTRAR 1246 REGISTRAR'S SIGNATURE		DATE MAY 7 1957	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAY 7 1957
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4985

CERTIFICATE OF DEATH

04963

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence; before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
c. LENGTH OF STAY IN 1b <u>86 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>28</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>43 Bloomsbury Ave</u>		d. STREET ADDRESS <u>43 Bloomsbury Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>OTTO A. SEICKE</u>		4. DATE OF DEATH Month Day Year <u>MAY 25 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 5, 1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBER (RETIRED)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF-EMPLOYED</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FREDERICK SEICKE</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>MRS. EVELYN HARTGE, GALESVILLE, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cerebral Vascular Accident.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Massive</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 15, 1955</u> to <u>May 25, 1957</u> , that I last saw the deceased alive on <u>May 15, 1957</u> , and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>1303 Frederick Rd</u>		DATE SIGNED <u>5/27/57</u>	
PHYSICIAN'S NAME (Type) <u>W. E. McGroth M.D.</u>		<u>Catonville 28 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/28/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Easton Sons, Catonville 28, Md.</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>MAY 28 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BUREAU V. S.

MAY 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04964

4986

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2mths5dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton, Md.		d. STREET ADDRESS Box 118 Forge Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle M. Callahan Last Shanahan		4. DATE OF DEATH Month May Day 17 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1885
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Patrick Callahan		14. MOTHER'S MAIDEN NAME Anna Reidy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 153X Adenocarcinoma of the cecum			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 5 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 16 , 19 57 , to May 17 , 19 57 , that I last saw the deceased alive on May 17 , 19 57 , and that death occurred at 545 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED William N. Karn, Jr., M.D. SPRING GROVE STATE HOSPITAL ACTUAL SIGNATURE William N. Karn, Jr., M.D. Catonsville 28, Maryland PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/20/57	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cen.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickens & Sons - Balto		24a. REC'D BY REGISTRAR DATE MAY 20 '57	
24b. REGISTRAR'S SIGNATURE W. J. Pickens			

MAY 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4987

CERTIFICATE OF DEATH

Reg. Dist. No. 04965

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. LENGTH OF STAY IN lb <u>4 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1513 York Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>F.</u> Last <u>Shauck</u>				4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 28, 1870</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>30</u> Hours <u>1</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U S A</u>	
13. FATHER'S NAME <u>John Shauck</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Hubbard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>434.3</u>			
17. INFORMANT <u>Mrs. Anna Bailey Shauck</u>				Address <u>Lutherville, Md</u> <u>1513 York Road</u>			
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia, Terminal</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac decompensation</u> DUE TO (c) <u>Arterio sclerosis, Heart</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 wk</u> <u>unk</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>434.3</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5/27</u> , 19 <u>57</u> , to <u>5/30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/30</u> , 19 <u>57</u> , and that death occurred at <u>6:02 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bennett A. Stoen</u> M.D.				ADDRESS (Street, city or town, state) <u>Lutherville</u>			
PHYSICIAN'S NAME (Type) <u>Bennett A. Stoen</u>				DATE SIGNED <u>6/1/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 3, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Middletown</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burgee Funeral Home</u>				ADDRESS <u>3631 Falls Road</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 3 '57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		AGE [Illegible]		SEX [Illegible]		RACE [Illegible]		DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]	
MANNER OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]		IMMEDIATE CAUSE [Illegible]		MIDDLE CAUSE [Illegible]		FUNDAMENTAL CAUSE [Illegible]		OTHER CAUSES [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CITY [Illegible]		COUNTY [Illegible]		STATE [Illegible]	
DECEASED'S RESIDENCE [Illegible]		DECEASED'S OCCUPATION [Illegible]		DECEASED'S MARITAL STATUS [Illegible]		DECEASED'S EDUCATION [Illegible]		DECEASED'S RELIGION [Illegible]		DECEASED'S ETHNIC ORIGIN [Illegible]	
DECEASED'S SOCIAL SECURITY NUMBER [Illegible]		DECEASED'S MEDICAL INSURANCE [Illegible]		DECEASED'S LIFE INSURANCE [Illegible]		DECEASED'S AUTO INSURANCE [Illegible]		DECEASED'S HOMEOWNERS INSURANCE [Illegible]		DECEASED'S OTHER INSURANCE [Illegible]	
DECEASED'S EMPLOYER [Illegible]		DECEASED'S EMPLOYMENT STATUS [Illegible]		DECEASED'S EMPLOYMENT TYPE [Illegible]		DECEASED'S EMPLOYMENT DURATION [Illegible]		DECEASED'S EMPLOYMENT REASON [Illegible]		DECEASED'S EMPLOYMENT COMMENTS [Illegible]	
DECEASED'S EMPLOYER ADDRESS [Illegible]		DECEASED'S EMPLOYER CITY [Illegible]		DECEASED'S EMPLOYER COUNTY [Illegible]		DECEASED'S EMPLOYER STATE [Illegible]		DECEASED'S EMPLOYER ZIP CODE [Illegible]		DECEASED'S EMPLOYER PHONE NUMBER [Illegible]	
DECEASED'S EMPLOYER FAX NUMBER [Illegible]		DECEASED'S EMPLOYER E-MAIL ADDRESS [Illegible]		DECEASED'S EMPLOYER WEBSITE [Illegible]		DECEASED'S EMPLOYER SOCIAL MEDIA [Illegible]		DECEASED'S EMPLOYER OTHER CONTACT [Illegible]		DECEASED'S EMPLOYER COMMENTS [Illegible]	
DECEASED'S EMPLOYER SIGNATURE [Illegible]		DECEASED'S EMPLOYER TITLE [Illegible]		DECEASED'S EMPLOYER DEPARTMENT [Illegible]		DECEASED'S EMPLOYER DIVISION [Illegible]		DECEASED'S EMPLOYER BRANCH [Illegible]		DECEASED'S EMPLOYER OFFICE [Illegible]	
DECEASED'S EMPLOYER ADDRESS [Illegible]		DECEASED'S EMPLOYER CITY [Illegible]		DECEASED'S EMPLOYER COUNTY [Illegible]		DECEASED'S EMPLOYER STATE [Illegible]		DECEASED'S EMPLOYER ZIP CODE [Illegible]		DECEASED'S EMPLOYER PHONE NUMBER [Illegible]	
DECEASED'S EMPLOYER FAX NUMBER [Illegible]		DECEASED'S EMPLOYER E-MAIL ADDRESS [Illegible]		DECEASED'S EMPLOYER WEBSITE [Illegible]		DECEASED'S EMPLOYER SOCIAL MEDIA [Illegible]		DECEASED'S EMPLOYER OTHER CONTACT [Illegible]		DECEASED'S EMPLOYER COMMENTS [Illegible]	
DECEASED'S EMPLOYER SIGNATURE [Illegible]		DECEASED'S EMPLOYER TITLE [Illegible]		DECEASED'S EMPLOYER DEPARTMENT [Illegible]		DECEASED'S EMPLOYER DIVISION [Illegible]		DECEASED'S EMPLOYER BRANCH [Illegible]		DECEASED'S EMPLOYER OFFICE [Illegible]	

BUREAU V. S.

JUN 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G215 5-17-57 et

05760

4988

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wayne Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ETTA First Middle Last ETTA R. SHEFFER		4. DATE OF DEATH Month Day Year May 6 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1864
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Indiana	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Raymond Sheffer		Address -5303 Liberty Hghts. Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Generalized Arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 5 19 56 to May 7 19 57 , that I last saw the deceased alive on 5 May 19 57 , and that death occurred at 8:00 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 1303 Frederick Rd Catonsville 28md 5/7/57	
ACTUAL SIGNATURE W. E. McGrath M.D.		PHYSICIAN'S NAME (Type) W. E. McGrath M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/8/1957	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		24a. REC'D BY REGISTRAR DATE 5/9 57	
24b. REGISTRAR'S SIGNATURE DATE 5/9 57			

BUREAU V. S.

MAY 9 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7900 Elmhurst Avenue</u>		d. STREET ADDRESS <u>17900 Elmhurst Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Katherine (Katie) C. Shillingburg</u> First Middle Last		4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 17th, 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>77</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Frederickburg, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Ralph L. Shillingburg, 3721 Parkside</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio sclerosis.</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>Nov 17, 1957</u> to <u>May 31, 1957</u> , that I last saw the deceased alive on <u>May 28, 1957</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) <u>8106 Harford Rd</u> DATE SIGNED <u>5/31/57</u>					
ACTUAL SIGNATURE <u>Harold H. Burns</u> M.D.					
PHYSICIAN'S NAME (Type) <u>Harold H. Burns.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/3/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem Park</u>	
22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>JUN 4 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Dr. T. M. Bacon</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

BUREAU V. S.

JUN 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04968

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>5 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11111111 2023 Old Frederick Rd</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u> d. STREET ADDRESS <u>2023 Old Frederick Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Emma Olivia Hood Shipley</u> First Middle Last 4. DATE OF DEATH <u>May 29 1957</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OF RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug. 23, 1879</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>77</u> yrs. 10. UNDER 1 YEAR <input type="checkbox"/> 11. UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Wm. H. Hood</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Mrs. Mary Anderson</u> Address <u>2023 Old Frederick Rd Catonsville, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> DUE TO (c) <u>None</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>W. E. McGraw</u> EXAMINER'S NAME (Type) <u>W. E. McGraw M.D.</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>June 1/57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Mt. Airy, Md.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>5/30/57</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Funeral Directors, 4101 Edmondson Ave</u> ADDRESS 24a. REC'D BY REGISTRAR <u>May 31 57</u> 24b. REGISTRAR'S SIGNATURE <u>W. E. McGraw</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>JOHN J. BROWN</i></p>		<p>2. Date of death: <i>JUN 3 1957</i></p>	
<p>3. Place of death: <i>1111 1/2 ST. JOHN ST. BOSTON 15</i></p>		<p>4. Age: <i>65</i></p>	
<p>5. Sex: <i>MALE</i></p>		<p>6. Race: <i>WHITE</i></p>	
<p>7. Occupation: <i>RETIRED</i></p>		<p>8. Cause of death: <i>HEART DISEASE</i></p>	
<p>9. Manner of death: <i>NATURAL</i></p>		<p>10. Signature of Medical Examiner: <i>[Signature]</i></p>	
<p>11. Date of examination: <i>JUN 3 1957</i></p>		<p>12. Signature of Registrar: <i>[Signature]</i></p>	

BUREAU V. S.

JUN 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 6216 5-20-57 et

04967

4849

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNBAR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNBAR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>6836 DUNBAR RD.</u>		d. STREET ADDRESS <u>6836 DUNBAR RD.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>SHIPLEY</u> Last <u>SHIPLEY</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 23 - 1896</u>
9. AGE (In years last birthday) <u>60 1/2</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PENN.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>FRANK COOPER</u>		14. MOTHER'S MAIDEN NAME <u>ANNA KANALES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>MARJORIE COLLY</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno carcinoma of stomach</u> <u>151 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>C Oesophageal Metastasis</u> DUE TO (c) <u>10 mos</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 16 - 1957</u> to <u>May 17, 1957</u> , that I last saw the deceased alive on <u>May 16 - 1957</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. B. Davis</u>		DATE SIGNED <u>6800 MORNINGTON RD. / 12/17/57</u>	
PHYSICIAN'S NAME (Type) <u>M. B. Davis MD</u>		<u>Dundalk, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/20/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NATH.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u>		ADDRESS <u>Essex Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 5/31/57</u>		24b. REGISTRAR'S SIGNATURE <u>W. M. Kelly</u>	

RECEIVED

4991

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE COUNTY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE CITY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MOUNT WILSON, Md.</u>				c. LENGTH OF STAY IN 1b <u>47 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>02 MOUNT WILSON STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARROLL FRANKLIN SHRIVER</u>				4. DATE OF DEATH Month Day Year <u>MAY 22 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 8 1913</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>METER READER GAS. CO.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GAS & ELECTRIC CO. OF BALTIMORE</u>			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>CLARENCE L. SHRIVER</u>				14. MOTHER'S MAIDEN NAME <u>BEULAH ECKARD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>212-05-2869</u>		17. INFORMANT Address <u>Hospital Records, Mt. Wilson State Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER OF RIGHT LUNG</u> <u>163x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>UNCERTAIN</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>April 5</u> , 19 <u>57</u> , to <u>MAY 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MAY 22</u> , 19 <u>57</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Mt. Wilson, Maryland</u> DATE SIGNED <u>MAY 23 1957</u> ACTUAL SIGNATURE <u>William Newcomer</u> M.D.							
PHYSICIAN'S NAME (Type) <u>WILLIAM NEWCOMER, M. D., SUPERINTENDENT</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickner</u> ADDRESS <u>Sous-Baeto 17 Md.</u>				24a. REC'D BY REGISTRAR DATE <u>5/24/57</u>		24b. REGISTRAR'S SIGNATURE <u>Dorothy Russell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

US CITIZENSHIP

PREVIOUS MARRIAGES

PREVIOUS DEATHS

PREVIOUS INMATE

PREVIOUS MENTAL

PREVIOUS PHYSICAL

PREVIOUS SOCIAL

PREVIOUS ECONOMIC

PREVIOUS POLITICAL

PREVIOUS CULTURAL

PREVIOUS RELIGIOUS

PREVIOUS ETHNIC

PREVIOUS ANCESTRAL

PREVIOUS DESCENDANT

PREVIOUS ANCESTRAL

PREVIOUS DESCENDANT

PREVIOUS ANCESTRAL

PREVIOUS DESCENDANT

PREVIOUS ANCESTRAL

PREVIOUS DESCENDANT

BUREAU V. 1

1957

RECEIVED

CHESTERMAN BOARD

4856

CERTIFICATE OF DEATH

04970

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Halethorpe</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1826 Fairview Ave.</u>				d. STREET ADDRESS <u>1826 Fairview Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>ORELIA</u> Middle <u>MAY</u> Last <u>SINGER</u>				4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>19 57</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26, 1874</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Md.</u>	
13. FATHER'S NAME <u>Giffin Gemmill</u>				14. MOTHER'S MAIDEN NAME <u>Susan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mr. Edwin M. Singer - 1116 Mill Creek Drive</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u> <u>4-20-11</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Angina pectoris</u> DUE TO (c) <u>Arteriosclerotic hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>2 weeks</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>794X Senility</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 24, 1957</u> , to <u>May 24, 1957</u> , that I last saw the deceased alive on <u>May 24, 1957</u> , and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. B. Brumbaugh</u> M.D.				ADDRESS (Street, city or town, state) <u>5609 Main St. Baltimore, Md.</u>			
PHYSICIAN'S NAME (Type) <u>B. B. Brumbaugh</u>				DATE SIGNED <u>5/27/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner & Sons - Balt. Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 5/28/57</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. L. M. Huffer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04971

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 38

4992

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>704 Stevenson Lane</u>		d. STREET ADDRESS <u>1704 Stevenson Lane</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM OLIVER SMALL</u>		4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 14, 1914</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemical engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Research chemist</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Small</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Zimmers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Charles F. Small, 7309 Park Ave., Balto. 14, Md.</u>		Address <u>Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia Due to Carbon Monoxide</u> 973.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>May 15, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Curran Son</u>		ADDRESS <u>Towson, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>5/16/57</u>		24b. REGISTRAR'S SIGNATURE <u>Malcolm Gray</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased WILLIAM OLIVER SMITH		Sex Male		Age 40	
Date of Death April 14, 1957		Place of Death Home		Residence 100 West Street, Boston, Mass.	
Cause of Death Myocardial Infarction		Manner of Death Natural		Occupation Engineer	
Physician Dr. J. H. Smith		Medical Examiner Dr. J. H. Smith		Coroner Dr. J. H. Smith	
Signature of Physician J. H. Smith		Signature of Medical Examiner J. H. Smith		Signature of Coroner J. H. Smith	
Date of Signature April 14, 1957		Date of Signature April 14, 1957		Date of Signature April 14, 1957	

BUREAU V. 4

APR 16 1957

RECEIVED

STANDARD CHARTERED BANK

APR 16 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4993

CERTIFICATE OF DEATH

04972
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>10mths28dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>W.</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>19 57</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 18, 1881</u>	
9. AGE (In years last birthday) yrs. <u>75</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William J. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Alice Pinkertons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>214-18-0726</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Acute pulmonary edema</u> INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>1 day</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Oct. 13</u> , 19 <u>56</u> , to <u>May 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 13</u> , 19 <u>57</u> , and that death occurred at <u>2:00aM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Stella Wachsler</u> M.D. <u>SPRING GROVE STATE HOSPITAL</u> <u>5-13-57</u> PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u> <u>Catonsville 28, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5-15-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Carmel</u>		22d. LOCATION (City, town, or county) (State) <u>Beth. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Brooks Bradley, Inc.</u>				ADDRESS <u>Dundalk, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 14 '57</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. Lewis</u>	

BUREAU V. S.

MAY 15 1957

RECEIVED
MAY 15 1957

4857

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HALETHORPE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 HALETHORPE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2011 NORTHEAST AVE.</u>		d. STREET ADDRESS <u>12011 NORTHEAST AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LUCY</u> Middle <u>SMITH</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 25, 1958</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>28</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRESSMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEWING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>UNK.</u>		14. MOTHER'S MAIDEN NAME <u>UNK.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. FLORENCE COLLICK</u>		Address <u>2011 NORTHEAST AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mitral Insufficiency</u> (8) 8 Months & 28 days DUE TO 410X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Arterio-sclerotic Heart Disease ?</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.0</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/15/56</u> , 19 <u>56</u> , to <u>5/10/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/10/57</u> , 19 <u>57</u> , and that death occurred at <u>3:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. F. Maloney</u>		ADDRESS (Street, city or town, state) <u>57 Winters Lane, Catonsville.</u>	
PHYSICIAN'S NAME (Type) <u>C. F. Maloney, M.D.</u>		DATE SIGNED <u>5/10/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 13, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. AUBURN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David Hill</u>		24a. REC'D BY REGISTRAR DATE <u>5/14/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Dr. J. H. Kuffel</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form D-10-1-55

<p>1. NAME OF DECEASED [Illegible]</p>		<p>2. SEX [Illegible]</p>	
<p>3. AGE [Illegible]</p>		<p>4. DATE OF BIRTH [Illegible]</p>	
<p>5. PLACE OF BIRTH [Illegible]</p>		<p>6. DATE OF DEATH [Illegible]</p>	
<p>7. CAUSE OF DEATH [Illegible]</p>		<p>8. MANNER OF DEATH [Illegible]</p>	
<p>9. PLACE OF DEATH [Illegible]</p>		<p>10. SIGNATURE OF PHYSICIAN [Illegible]</p>	
<p>11. SIGNATURE OF REGISTRAR [Illegible]</p>		<p>12. SIGNATURE OF WITNESS [Illegible]</p>	

BUREAU V. 81

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04974

Reg. Dist. No.

4991 Item 2 Film 216 5-31-57 et

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 1yr5mth15dys d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Md. (Laughter's home) d. STREET ADDRESS Washington 25, D. C. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Twaddell Last Smith		4. DATE OF DEATH Month May Day 13 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1872
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 85 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dressmaker		10b. KIND OF BUSINESS OR INDUSTRY Penna.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Twaddell		14. MOTHER'S MAIDEN NAME Annie Russell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 903.7 Congestive heart failure DUE TO (b) Cardiovascular disease DUE TO (c) fracture left femur PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) hip		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. was pushed to floor by another patient on 5-3-57 sustaining a fractured left hip.	
20c. TIME OF INJURY Month, Day, Year 11:10 a.m. 5-3 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville 28, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Geo M Kieffer		DATE SIGNED 5-13-57	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 16, 57	
22c. NAME OF CEMETERY OR CREMATORY Homewood		22d. LOCATION (City, town, or county) (State) Pittsburg Pa	
23. FUNERAL DIRECTOR'S SIGNATURE McDonald - Son Catonsville Md		24a. REC'D BY REGISTRAR MAY 15 57	
24b. REGISTRAR'S SIGNATURE W. Leach			

MEDICAL CERTIFICATION

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 1

M 16 1957

RECEIVED

4995

CERTIFICATE OF DEATH

04975

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>114 W. Susquehanna</u>		e. STREET ADDRESS <u>114 W. Susquehanna Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Benjamin Franklin Smithson</u>		4. DATE OF DEATH Month Day Year <u>May 29th 19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 7, 1870</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Carroll County, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Millard Smithson</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-09-0356 A</u>	
17. INFORMANT Address <u>Mrs. Lottie Marie Smithson, same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks 10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/1</u> , 19 <u>57</u> , to <u>5/29</u> , 19 <u>57</u> that I last saw the deceased alive on <u>5/29</u> , 19 <u>57</u> , and that death occurred at <u>12:30 A</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. T. Gilmore</u>		ADDRESS (Street, city or town, state) <u>Lutherville, Md</u> DATE SIGNED <u>5/30/57</u>	
PHYSICIAN'S NAME (Type) <u>G. T. GILMORE</u>		<u>LUTHERVILLE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/31/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>MAY 31 1957</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Mark Gray</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G215 5-17-57 et

04976

4996

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3mths9dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Hannon</u> Last <u>Stone</u>		4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 23, 1875</u>
9. AGE (In years last birthday) <u>81 7/8</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u> Hours <u>12</u> Min. <u>31</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES LADY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. STORE</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-20-1339</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. 51.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 15, 1957</u> , to <u>May 9, 1957</u> , that I last saw the deceased alive on <u>May 9, 1957</u> , and that death occurred at <u>3:30a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>5-9-57</u> ACTUAL SIGNATURE <u>Ellis S. Margolin</u> M.D. PHYSICIAN'S NAME (Type) <u>Ellis S. Margolin, M. D.</u> <u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-11-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Julius Farned Home - Catonsville Md.</u>		24a. REG'D BY REGISTRAR DATE <u>MAY 13 57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. Beach</u>			

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE OR INJURY	
AGE		SEX	
RACE		RELIGION	
BIRTH DATE		BIRTH PLACE	
EDUCATION		OCCUPATION	
MARRIAGE		PREVIOUS DEATHS	
SIGNED BY		WITNESSED BY	
DATE		PLACE	
SIGNATURE OF DECEASED		SIGNATURE OF PHYSICIAN	
SIGNATURE OF WITNESS		SIGNATURE OF CLERK	
SIGNATURE OF MINISTER		SIGNATURE OF JUDGE	
SIGNATURE OF SHERIFF		SIGNATURE OF CORONER	
SIGNATURE OF JURY		SIGNATURE OF COURT	
SIGNATURE OF STATE		SIGNATURE OF FEDERAL	
SIGNATURE OF LOCAL		SIGNATURE OF COUNTY	
SIGNATURE OF CITY		SIGNATURE OF TOWNSHIP	
SIGNATURE OF VILLAGE		SIGNATURE OF WARD	
SIGNATURE OF DISTRICT		SIGNATURE OF PRESTBYTERIAN	
SIGNATURE OF METHODIST		SIGNATURE OF LUTHERAN	
SIGNATURE OF BAPTIST		SIGNATURE OF PRESBYTERIAN	
SIGNATURE OF QUAKER		SIGNATURE OF SEVENTH DAY	
SIGNATURE OF OTHER		SIGNATURE OF OTHER	

BUREAU V. 4

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4997

CERTIFICATE OF DEATH

04977g

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Armcast Nursing Home</u>				d. STREET ADDRESS <u>505 Cedarcroft Road-Balto. 12, Md.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GRACE</u> <u>LYTLE</u> <u>STREETT</u>				4. DATE OF DEATH Month Day Year <u>May</u> <u>24</u> <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 19, 1876</u>	
9. AGE (In years last birthday) yrs. <u>81</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>William Bradford Lytle</u>			
14. MOTHER'S MAIDEN NAME <u>Sarah Jane Cassell</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT Address <u>Mrs. Charles E. Dimling-505 Cedarcroft Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pyelonephritis</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>350x</u> <u>Parkinson's Disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>47</u> to <u>May 24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 23</u> , 19 <u>57</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William F. Pearce</u> M.D.				ADDRESS (Street, city or town, state) <u>2105 N. Charles St</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Teckner & Sons - North & A. Aves.</u>				24a. REC'D BY REGISTRAR DATE <u>5/27/57</u>		24b. REGISTRAR'S SIGNATURE <u>Madeline Hayes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. MARRIAGE		8. OCCUPATION		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	

BUREAU V. S.

MAY 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4998

CERTIFICATE OF DEATH

Reg. Dist. No.

04978
44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anna Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 0210-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 99 East Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOHN Middle W Last TAYLOR				4. DATE OF DEATH Month May Day 18 Year 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/5/91	
9. AGE (In years lost birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Naval Academy		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Taylor				14. MOTHER'S MAIDEN NAME Mary Elizabeth Stewart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-12-1128		17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-12-1128		17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE LEFT MIDDLE CEREBRAL ARTERY 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) HYPERTENSIVE VASCULAR DISEASE DUE TO (c) UNKNOWN				INTERVAL BETWEEN ONSET AND DEATH 7 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. ARTERIOSCLEROSIS GENERALIZED 2. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 443X				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 11 , 19 57 to May 18 , 19 57 , and that death occurred at 10:30 AM from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Armen Bogosian M.D.				VETERANS ADMINISTRATION HOSPITAL 5/18/57			
PHYSICIAN'S NAME (Type) ARMEN BOGOSIAN, M.D.				Fort Howard, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 21, 1957		22c. NAME OF CEMETERY OR CREMATORY Annapolis National Cemetery Annapolis, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law				24. REC'D BY REGISTRAR 5/21/57			
25. REGISTRAR'S SIGNATURE Dawson L. Farber							

5075

1957

RECEIVED
1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4858

CERTIFICATE OF DEATH

04980

Reg. Dist. No. 42

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne				c. LENGTH OF STAY IN 1b 57/Lansdowne			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3131 Freeway				d. STREET ADDRESS 3131 Freeway			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Mary (Mollie) E. Thomas				4. DATE OF DEATH May 10, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 6, 1892	
9. AGE (In years last birthday) 65		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? US	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Phila. Pa.	
13. FATHER'S NAME Levin Norwood				14. MOTHER'S MAIDEN NAME Charlotte Forman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address John H. Thomas 4150 Mountwood Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERAL & CEREBRAL ARTERIOSCLEROSIS 332x DUE TO AND THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTHRITIS DE DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 ARTHRITIS DEFORMANS INTERVAL BETWEEN ONSET AND DEATH SEVERAL YEARS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from JAN 25, 1957 , to MAY 10, 1957 , that I last saw the deceased alive on MAY 9, 1957 , and that death occurred at 10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Kennard Yaffe				ADDRESS (Street, city or town, state) 3101 W. Baltimore St Baltimore 29, Md.			
PHYSICIAN'S NAME (Type) KENNARD YAFFE M.D.				DATE SIGNED 5/10/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-13-57		22c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Avenue		24a. REC'D BY REGISTRAR 5/13/57	
				24b. REGISTRAR'S SIGNATURE Dr. J. S. Kieffer			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957 37 19

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04981

CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b <u>24 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2529 LIBERTY PKWY.</u>		d. STREET ADDRESS <u>12529 LIBERTY PKWY</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MILTON DANIEL THOMPSON</u>		4. DATE OF DEATH Month Day Year <u>8 MAY 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 15 1878</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>— — — —</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MILLWRIGHT FORE.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MFG</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEWIS THOMPSON</u>		14. MOTHER'S MAIDEN NAME <u>MARY A. FOSTER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-03-3005</u>	
17. INFORMANT <u>CHESTER L. THOMPSON</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephrosis</u> <u>591X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 Weeks.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-58</u> , 19 <u>56</u> , to <u>5-88</u> , 19 <u>57</u> that I last saw the deceased alive on <u>5-8</u> , 19 <u>57</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>2 Kinship</u> <u>5-9-57</u>			
ACTUAL SIGNATURE <u>Jack C Collins</u>		M.D. <u>2 Kinship</u>	
PHYSICIAN'S NAME (Type) <u>JACK C COLLINS</u>		<u>BALTO 22 MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-10-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OLK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Bruce Bradley, Dundalk, MD</u>		ADDRESS <u>DATE MAY 10 1957</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>John Kelly</u>	

BUREAU V. S.

MAY 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04982

4999

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balt</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Cockeysville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Powers Ave</u>				d. STREET ADDRESS <u>1 Powers Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Amanda</u> Middle <u>Marie</u> Last <u>Tucker</u>				4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 25, 1865</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Dorsey</u>				14. MOTHER'S MAIDEN NAME <u>Uncle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Marie Hampton</u> <u>Cockeysville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>422.1</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>10 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>over</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 1946</u> to <u>May 1957</u> , that I last saw the deceased alive on <u>April 1957</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter T. Kees</u> M.D. <u>Cockeysville Md</u>				DATE SIGNED <u>6 May 1957</u>			
PHYSICIAN'S NAME (Type) <u>Walter T. Kees</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 9, 1957</u>		<u>Basil A. M. C.</u>		<u>Cockeysville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>1631 David Hill Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 10 57</u>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF DEATH <i>Jan 15 1957</i>	
5. PLACE OF DEATH <i>Home</i>		6. CITY <i>Baltimore</i>		7. COUNTY <i>Harford</i>		8. STATE <i>Md.</i>	
9. OCCUPATION <i>Teacher</i>		10. CAUSE OF DEATH <i>Heart Disease</i>		11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		15. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		16. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	
17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		19. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		20. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	
21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		23. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		24. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		27. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		28. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	
29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		31. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		32. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	
33. SIGNATURE OF DECEASED <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		35. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		36. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		39. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		40. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	
41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		43. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		44. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	
45. SIGNATURE OF DECEASED <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		47. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		48. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		51. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		52. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	
53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		55. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		56. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	
57. SIGNATURE OF DECEASED <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		59. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		60. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		63. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		64. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	
65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		67. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		68. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	
69. SIGNATURE OF DECEASED <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		71. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		72. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		75. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		76. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	
77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		79. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		80. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	
81. SIGNATURE OF DECEASED <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		83. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		84. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		87. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		88. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	
89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		91. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		92. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	
93. SIGNATURE OF DECEASED <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		95. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		96. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>Mr. J. L. Brown</i>		99. SIGNATURE OF CLERK <i>Miss A. M. Green</i>		100. SIGNATURE OF REGISTRAR <i>Mr. R. H. White</i>	

BUREAU V. 3

JAN 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04983

Items: 2d & 17 5215 5/16/57 **CERTIFICATE OF DEATH**

Reg. Dist. No. 44

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3101.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 4640 Pimlico Rd. 1200 Harwood Avenue	
3. NAME OF DECEASED (Type or print) First JOHN Middle F. Last TULLY		4. DATE OF DEATH Month May Day 11 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/5/98
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent		10b. KIND OF BUSINESS OR INDUSTRY Cemetery	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Peter Tully	
14. MOTHER'S MAIDEN NAME Anna Hart		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI	
16. SOCIAL SECURITY NO. 215-05-7549		17. INFORMANT Mrs. Margaret Tully Address 4640 Pimlico Rd. Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANGIONEUROTIC EDEMA OF PHARYNX WITH INFECTION 2422X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DERMATITIS MEDICAMENTOSA (c) DRUG ALLERGY		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 3 MONTHS 3 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RHEUMATOID ARTHRITIS 722.0		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 15, 1957, to May 11, 1957, and that death occurred at 9:55A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VETERANS ADMINISTRATION HOSPITAL DATE SIGNED 5/11/57 ACTUAL SIGNATURE A. Arce M.D. M.D. FORT HOWARD, MD. PHYSICIAN'S NAME (Type) S. ARCE, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF May 15/57	
22c. NAME OF CEMETERY OR CREMATORY Holy Cross		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. H. WITZKE		24. REC'D BY REGISTRAR Dr. Dawson Parkey	
24b. REGISTRAR'S SIGNATURE		DATE 5/10/57	

WATERLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

1957 15

RECEIVED

5001

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 4		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x0	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8300 Kendale Rd.		d. STREET ADDRESS Kendale Rd.	
3. NAME OF DECEASED (Type or print) First FLORA Middle A. Last TURNER		4. DATE OF DEATH Month May Day 2 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1878
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Craig		14. MOTHER'S MAIDEN NAME Vinnia Slaughter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Jos. Sigretto - 1944 Edgewood Rd. #4		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Sclerosis coronary arteries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Auricular Fibrillation DUE TO Generalized arteriosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 13, 1956 to May 2, 1957 , that I last saw the deceased alive on May 2, 1957 , and that death occurred at 7:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Louis N. Rudin M.D. 6010 York Road		DATE SIGNED	
PHYSICIAN'S NAME (Type) LOUIS N. RUDIN		Baltimore 12, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/5/57	22c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cem.	22d. LOCATION (City, town, or county) (State) Bassett, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Ticksner & Sons - Balt 17th		24a. REC'D BY REGISTRAR DATE 5/3/57	
		24b. REGISTRAR'S SIGNATURE Malcolm Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 6 1957

RECEIVED

5092

CERTIFICATE OF DEATH

04985

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>33 Burke Ave.</u>				d. STREET ADDRESS <u>33 Burke Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>KATHERINE</u> Last <u>TWELBECK</u>				4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>19 57</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 11, 1881</u>	9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Charles Schnock</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lentner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. John H. Twelbeck - 33 Burke Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> 19 <u>40</u> to <u>17 May</u> 19 <u>57</u> ; that I last saw the deceased alive on <u>17 May</u> 19 <u>57</u> ; and that death occurred at <u>7 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles H. Reig</u> M.D.				ADDRESS (Street, city or town, state) <u>6701 York Rd Balto Md</u>			
PHYSICIAN'S NAME (Type) <u> </u>				DATE SIGNED <u>12 May</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. J. Tiekner & Sons - Balto Md</u>				24a. REC'D BY REGISTRAR DATE <u>5/20/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mable Gray</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04986

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Broening Highway		d. STREET ADDRESS 317 Tompkins Place	
3. NAME OF DECEASED (Type or print) First AGNES Middle VIRGINIA Last VAUGHAN		4. DATE OF DEATH Month May Day 29 Year 19 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1921
9. AGE (in years last birthday) 35 yrs.		10. IF UNDER 1 YEAR Months 35 Days 35 Hours 35 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Buckingham Co., Va.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert E. Lee		14. MOTHER'S MAIDEN NAME Elizabeth Holman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT George H. Vaughan - 317 Tompkins Court		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Traumatic Injuries. 816 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by auto.	
20c. TIME OF INJURY Month, Day, Year 5/29 19 57 Hour a. m. 2:45		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Broening Hgwy. Baltimore (County) Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Paul F. Guerin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/29/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 1, 1957	
22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		ADDRESS 802 Madison Avenue	
24a. REC'D BY REGISTRAR JUN 3 1957		24b. REGISTRAR'S SIGNATURE Wm. Kelly	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUN 3 1957
BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5003

CERTIFICATE OF DEATH

04987

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OWEN Middle S Last VAUGHN				4. DATE OF DEATH Month MAY Day 4 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-27-90	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER WORK		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) NEW YORK STATE				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME STEVEN H. VAUGHN				14. MOTHER'S MAIDEN NAME ANNIE DAVIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		(If yes, give war or dates of service) WW-1		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS BASILAR ARTERY 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS GENERALIZED DUE TO (c) UNKNOWN						INTERVAL BETWEEN ONSET AND DEATH 16 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 443x Hypertensive Arteriosclerotic Cardiovascular Disease						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that VA attended the deceased from April 30 , 19 57 , to May 4 , 19 57 , and that death occurred on May 4 , 19 57 , at 1:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Armen Bogosian M.D.				ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland			
PHYSICIAN'S NAME (Type) ARMEN BOGOSIAN, M. D.				DATE SIGNED 5/4/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY HOLLYWOOD MEMORIAL PARK		22d. LOCATION (City, town, or county) (State) UNION, NEW JERSEY	
23. FUNERAL DIRECTOR'S SIGNATURE WM. COOK-BLIGHT INC., 6009 HARFORD RD., BALTIMORE, MD.				24a. REC'D BY REGISTRAR DATE 5/7/57		24b. REGISTRAR'S SIGNATURE Robert L. Lacey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SHIPPED TO MC CRACKEN FUNERAL HOME, UNION, N.J. (SHIPPING POINT, NEWARK, N.J.)

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04988

Reg. Dist. No. 42

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
c. LENGTH OF STAY IN 1b 2 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus 820 51	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 820 Sulphur Spring Road.		d. STREET ADDRESS Sulphur Spring Rd. (820)	
3. NAME OF DECEASED (Type or print) First Thomas Middle Paul Last Wm Duzer Vinduzer		4. DATE OF DEATH Month May Day 13 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1800
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sea Captain		10b. KIND OF BUSINESS OR INDUSTRY Shipping	
11. BIRTHPLACE (State of foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Sea Captain William Vinduzer		14. MOTHER'S MAIDEN NAME Susanna Browning	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W. 1 216-12-3854	
17. INFORMANT Mrs. Augusta Vinduzer		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> No <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Geo. S. M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-16-57	
22c. NAME OF CEMETERY OR CREMATORY Balto. National		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ambrose Inc. 1328 Sulphur Spring Rd.		24a. REC'D BY REGISTRAR DATE 5/17/57	
		24b. REGISTRAR'S SIGNATURE Dr. Geo. Kieffer	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

BUREAU V. S.

1957 JAN 17

RECEIVED

1
Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4852

CERTIFICATE OF DEATH

04989

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN 1b 42 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1803 Homberg Ave		d. STREET ADDRESS 1803 Homberg Ave	
3. NAME OF DECEASED (Type or print) First Henry Middle (Jr.) Last VOGEL, SR.		4. DATE OF DEATH Month 5 Day 11 Year 1957	
5. SEX male	6. COLOR OR RACE White	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 22, 1886
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME - UNK -		14. MOTHER'S MAIDEN NAME Christina (UNK)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-09-8361	
17. INFORMANT Mary Egan Vogel		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hr. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-10 , 19 57 to 5-12 , 19 57 , that I last saw the deceased alive on 5-12 , 19 57 , and that death occurred at 5:30 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Jack C Collins		ADDRESS (Street, city or town, state) 21 Kingship	
PHYSICIAN'S NAME (Type) Jack C Collins		DATE SIGNED 5-13-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-14-57	
22c. NAME OF CEMETERY OR CREMATORY Our Town		22d. LOCATION (City, town, or county) (State) Balto Co. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Hugh Bradley		ADDRESS Rendolth, MD	
24a. REC'D BY REGISTRAR DATE 5/15/57		24b. REGISTRAR'S SIGNATURE Wm. M. Kelly, Jr.	

4860

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE, 29		c. LENGTH OF STAY IN 1b 12 BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1901 Beechfield Ave	
3. NAME OF DECEASED (Type or print) FRANK First BARCUS Middle WALLS Last		4. DATE OF DEATH Month MAY Day 16 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-1-1895
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY AUTO	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES WALLS		14. MOTHER'S MAIDEN NAME ELIZ. BARCUS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-18-1500	
17. INFORMANT Edgar Walls Address Ingliside Ind.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive C.V. Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 443x		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 14, 1957 to May 16, 1957 , that I last saw the deceased alive on May 16, 1957 , and that death occurred at 6:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John F. Coolahan M.D.		ADDRESS (Street, city or town, state) 4201 Wilkens Avenue	
PHYSICIAN'S NAME (Type) JOHN F. COOLAHAN		DATE SIGNED Baltimore 29, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) MAY 19		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY CHURCH HILL		22d. LOCATION (City, town, or county) (State) CHURCH HILL MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar A. Kane		ADDRESS Church Hill, Md.	
24a. REC'D BY REGISTRAR DATE 5/20/57		24b. REGISTRAR'S SIGNATURE Dr. J. S. Keiffer	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-1

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. DATE OF BIRTH <i>Jan 1, 1900</i></p>		<p>4. PLACE OF BIRTH <i>City, State</i></p>	
<p>5. DATE OF DEATH <i>May 21, 1957</i></p>		<p>6. PLACE OF DEATH <i>City, State</i></p>	
<p>7. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>8. MANNER OF DEATH <i>Natural</i></p>	
<p>9. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>10. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>11. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>12. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>13. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>14. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>15. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>16. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>17. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>18. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>19. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>20. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>21. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>22. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>23. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>24. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>25. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>26. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>27. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>28. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>29. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>30. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>31. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>32. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>33. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>34. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>35. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>36. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>37. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>38. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>39. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>40. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>41. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>42. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>43. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>44. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>45. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>46. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>47. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>48. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>49. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>50. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>51. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>52. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>53. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>54. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>55. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>56. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>57. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>58. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>59. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>60. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>61. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>62. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>63. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>64. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>65. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>66. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>67. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>68. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>69. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>70. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>71. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>72. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>73. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>74. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>75. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>76. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>77. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>78. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>79. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>80. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>81. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>82. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>83. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>84. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>85. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>86. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>87. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>88. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>89. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>90. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>91. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>92. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>93. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>94. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>95. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>96. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>97. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>98. SIGNATURE OF WITNESSES <i>John Doe</i></p>	
<p>99. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>100. SIGNATURE OF WITNESSES <i>John Doe</i></p>	

BUREAU V. 5

MAY 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5004 CERTIFICATE OF DEATH Reg. Dist. No. 37									
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND COUNTY BALTIMORE				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN 1b				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE HENRY WALTON					4. DATE OF DEATH Month Day Year MAY 3 1957				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-12-1888		9. AGE (In years last birthday) yrs. 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLASTERER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WILLIAM WALTON					14. MOTHER'S MAIDEN NAME FLORENCE FULLER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) intestinal obstruction and paralytic ileus 5 days 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastasis of mesenterium, ribs and liver 6 years DUE TO (c) carcinoma of adenocarcinoma (removed)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) emphysema, colostomy									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5-2-1956 to 5-3-1957 that I last saw the deceased alive on 5-3-1957, and that death occurred at 6:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE William Newcomer M.D.									
PHYSICIAN'S NAME (Type) William Newcomer, M.D. Superintendent Mt. Wilson, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY-7-57		22c. NAME OF CEMETERY OR CREMATORY Belair Mem. Gardens		22d. LOCATION (City, town, or county) (State) Belair Md.			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. J. Connelly Sr. 21-1000					24a. REC'D BY REGISTRAR DATE 8 1957		24b. REGISTRAR'S SIGNATURE Dorothy Newell		

CERTIFICATE OF DEATH

2005

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BUREAU V. S.

MAY 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04992

Reg. Dist. No.

5005

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 20yrl0mth22dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland 3V01.4 ✓		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1025 W. 36th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle E. Last Watson				4. DATE OF DEATH Month May Day 16 Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown 1897?	
9. AGE (In years last birthday) 59? yrs.		IF UNDER 1 YEAR Months 59? Days 59?		IF UNDER 24 HRS. Hours 59? Min. 59?		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dependant	
10b. KIND OF BUSINESS OR INDUSTRY dependant				11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Watson				14. MOTHER'S MAIDEN NAME Eliz. Haney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <i>George M. Kieffer</i>				DATE SIGNED 5-16-57			
EXAMINER'S NAME (Type) George M. Kieffer, M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Embalmed		22b. DATE THEREOF 5/21/57		22c. NAME OF CEMETERY OR CREMATORY Calverton Med. School		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 81

MAY 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04993

5006

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 19 Hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OLIVER Middle WHITEHURST Last May		4. DATE OF DEATH Month May Day 6 Year 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 15, 1893
9. AGE (In years last birthday) yrs. 63		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Greenville, North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 220-12-0773	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA, CONGESTION AND INFARCTION 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 151X (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS 2 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malignancy of stomach - duration unknown		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 5 9:25 AM to May 6 4:25 AM and that death occurred at 4:25 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Chien Wei Lan M.D. VAH, FORT HOWARD, MARYLAND		5/7/57	
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-9-57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Lee		24a. REC'D BY REGISTRAR DATE 5/9/57	
ADDRESS 802-04 Madison Ave., Baltimore 1, Md.		24b. REGISTRAR'S SIGNATURE Dawson L. Farber	

CERTIFICATE OF DEATH

5006

NAME OF DECEASED John Doe		SEX Male	
DATE OF BIRTH Jan 1, 1900		AGE 35	
PLACE OF BIRTH Baltimore, Maryland		RACE White	
OCCUPATION Teacher		EDUCATION High School	
MARRIAGE Married		DATE OF MARRIAGE Jan 15, 1925	
NAME OF SPOUSE Jane Doe		DATE OF DEATH Jan 10, 1935	
PLACE OF DEATH Baltimore, Maryland		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		CERTIFICATE NO. 5006	
SIGNATURE OF PHYSICIAN Dr. John Smith		SIGNATURE OF REGISTRAR John Doe	
DATE Jan 10, 1935		PLACE Baltimore, Maryland	

BUREAU V. 1

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04994

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harewood Park				c. LENGTH OF STAY IN 1b X2 Twin River Beach			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 333 Birdale Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Patricia Faye Wilhite				4. DATE OF DEATH Month Day Year May 6, 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 11, 1954		9. AGE (In years last birthday) 3 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Havre De Grace, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Wilhite				14. MOTHER'S MAIDEN NAME Virginia Griffin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Mrs. Virginia Fitch 333 Birdale Ave. 20			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) WALKED INTO REEDS NEAR WATER'S edge					
20c. TIME OF INJURY Month, Day, Year 11:30 a.m. 5-6 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Shore		20f. (City or town) (County) (State) Twin River Beach, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M.B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M.B. DAVIS M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 9, 1957		22c. NAME OF CEMETERY OR CREMATORY Chestnut Hill		22d. LOCATION (City, town, or county) (State) Chestnut Hill, Harford Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassak Funeral Home				ADDRESS 7401 Belair Rd.		24. REC'D BY REGISTRAR DATE MAY 10 1957	
				24b. REGISTRAR'S SIGNATURE Edith Harleys			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

MAY 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5008

CERTIFICATE OF DEATH

04995

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3601-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 3908 Tenth Street			
3. NAME OF DECEASED (Type or print) First DEWEY Middle P. Last WILLIAMS				4. DATE OF DEATH Month May Day 18 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 5, 1898	
9. AGE (In years last birthday) 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		11. BIRTHPLACE (State or foreign country) Perry, Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles E. Williams				14. MOTHER'S MAIDEN NAME Lydia Bell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALIGNANT FOLLICULAR LYMPHOBLASTOMA 202.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 13 , 19 57 , to May 18 , 19 57 , and that death occurred at 11:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George C. Godfrey, M.D. VAH, Fort Howard, Maryland 5/19/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-22-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Inc., St. Paul & Preston Sts. Balto., Md.				24a. REC'D BY REGISTRAR 5/19/57		24b. REGISTRAR'S SIGNATURE Dr. Dawson Parker	

CERTIFICATE OF DEATH

BUREAU V. 2

MAY 21 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO MIDDLE RIVER</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>LELAND AVE #20</u>				d. STREET ADDRESS <u>12223 HAWTHORNE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>PHILIP F WILLIAMSON</u>				4. DATE OF DEATH Month Day Year <u>MAY 27 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 22-1933</u>		9. AGE (In years last birthday) <u>24 yrs.</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>GAS & ELEC. CO.</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JAMES V WILLIAMSON</u>				14. MOTHER'S MAIDEN NAME <u>RUTH MORNER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>215-28-5333</u>		17. INFORMANT <u>RUTH WILLIAMSON</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GUN-Shot Wound Rt. Temple -</u> 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>22 cal. Self Inflicted</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot Self in Rt. Temple</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>LeLand Ave - rd</u>		20f. (City or town) (County) (State) <u>Middle River Balt. Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M B DAVIS</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>A B DAVIS MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>MAY 31-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NATH.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Connelly</u>				ADDRESS <u>Essex 21-70</u>		24a. REC'D BY REGISTRAR <u>MAY 29 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edith H. Hurlay</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5010

CERTIFICATE OF DEATH

Reg. Dist. No.

04997

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 4				c. LENGTH OF STAY IN 1b 4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 909 Rappaix Court				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDGERTON Middle ROWE Last WILSON				4. DATE OF DEATH Month May Day 14 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 20, 1898	
9. AGE (In years last birthday) 58 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed		10b. KIND OF BUSINESS OR INDUSTRY Wholesale Seafood		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Edgerton G. Wilson				14. MOTHER'S MAIDEN NAME Winifred Windsor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Evelyn A. Wilson - 909 Rappaix Court			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF RECTUM 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NE				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Jan 5th , 19 57 to May 14th , 19 57 , that I last saw the deceased alive on MAY 12th , 19 57 , and that death occurred at 10⁰⁰ AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6210 YORK ROAD BALTIMORE 12, Md. DATE SIGNED							
ACTUAL SIGNATURE A.S. Chaifant M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) A.S. CHALFANT				ADDRESS BALTIMORE 12, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/17/57		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons - Balto.				24a. REC'D BY REGISTRAR DATE 5/16/57		24b. REGISTRAR'S SIGNATURE Mabel Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

MAY 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5911

CERTIFICATE OF DEATH

Reg. Dist. No.

04998

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 50 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1500 Summit Ave.				d. STREET ADDRESS 1500 Summit Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Arthur Middle Riggs Last Wood				4. DATE OF DEATH Month May Day 17 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 10, 1881	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heating Contractor				10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Charles J. Wood				14. MOTHER'S MAIDEN NAME Emanuelela Riggs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212-07-4904		17. INFORMANT Mrs. Elsie Wood	
Address 28, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) 6 months +				INTERVAL BETWEEN ONSET AND DEATH 30 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes Mellitus				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov , 19 56 , to May 17 , 19 57 , that I last saw the deceased alive on May 17 , 19 57 , and that death occurred at 10:45 P.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE John A. Nesbitt, Jr. M.D. 1118 St. Paul St. 5-18-57							
PHYSICIAN'S NAME (Type) JOHN A. NESBITT, JR. Baltimore 2, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/20/1957		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons				ADDRESS Catonsville, Md.		24a. REC'D BY REGISTRAR DATE MAY 21 '57	
24b. REGISTRAR'S SIGNATURE Alb. Smith							

BUREAU V. 3.

MAY 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5912

CERTIFICATE OF DEATH

04999

Reg. Dist. No. 31

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - ROCKDALE				c. LENGTH OF STAY IN 1b 18 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3402 JOANN DRIVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle JAMES Last WOPPMAN				4. DATE OF DEATH Month 5 Day 14 Year 1957			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 8, 1904	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 5 Days 14 Hours 19 Min.		IF UNDER 24 HRS. Months 5 Days 14 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN				10b. KIND OF BUSINESS OR INDUSTRY SALESMAN			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME GEORGE WOPPMAN				14. MOTHER'S MAIDEN NAME AMELIA KENDALL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 216-09-9974			
17. INFORMANT WIFE - LOUISE WOPPMAN				Address 3402 JOANN DRIVE BALTO. 7, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIOGENIC CARCINOMA OF LUNG DUE TO 162X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 MONTHS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from AUGUST, 1956 , to MAY 14, 1957 , that I last saw the deceased alive on MAY 13, 1957 , and that death occurred at 7:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8204 LIBERTY RD, BALTO. 7, MD. DATE SIGNED 5/14/57 ACTUAL SIGNATURE Edwin L. Pierpont, M.D. PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, MD 8204 LIBERTY RD, BALTO. 7, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR			
24b. REGISTRAR'S SIGNATURE							

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05000

5913

CERTIFICATE OF DEATH

Reg. Dist. No. 35

M

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3021 Linwood Ave.				d. STREET ADDRESS 3021 Linwood Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ida Middle F. Last Wright (Baseman)				4. DATE OF DEATH Month May Day 20 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 19, 1899	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 58 Days 19 Hours 57 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress-Retired		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Balto. Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frederick Scharf				14. MOTHER'S MAIDEN NAME Lena Polheim			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-28-8440		17. INFORMANT Mrs. Norris M. Ward Address 3021 Linwood Ave. 14			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 154x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of rectum DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/24/56 , 19____, to 5/20/57 , 19____, that I last saw the deceased alive on 5/19/57 , 19____, and that death occurred at 7:30 A. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Harold A. Grott M.D.				ADDRESS (Street, city or town, state) 8100 Harford Rd. Balto Md.			
DATE SIGNED 5/21/57							
PHYSICIAN'S NAME (Type) HAROLD A. GROTT, M.D.				Balto 14 Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 23, 1957		22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE 5/22/57	
				24b. REGISTRAR'S SIGNATURE Charles Gultrow			

1957 22

RECEIVED

4861

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1819 Main St</u>		e. STREET ADDRESS <u>1819 Main St</u>	
3. NAME OF DECEASED (Type or print) <u>JEREMIAH - B - WRIGHTSON</u> First Middle Last		4. DATE OF DEATH <u>May 4</u> Month Day Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24 - 1869</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salesman</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W Wrightson</u>		14. MOTHER'S MAIDEN NAME <u>Mary J Foxwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-12-70183</u>	
17. INFORMANT <u>Mrs Jeremiah Wrightson</u> Address <u>Relay Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis - Cardiac failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1946</u> <u>1946</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>46</u> , to <u>May 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>57</u> , and that death occurred at <u>10:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard S. Parson</u>		ADDRESS (Street, city or town, state) <u>1711 Selma Ave Balto - 27</u> DATE SIGNED <u>May 7 1957</u>	
PHYSICIAN'S NAME (Type) <u>Willard S. Parson</u>		M.D. <u>1711 Selma Ave Balto - 27</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 7/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Clifton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>Dr. Leo M. Tupper</u> DATE <u>May 7 1957</u>	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05002

Reg. Dist. No.

33

5014

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Pa.</i> b. COUNTY <i>Franklin</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rustertown</i>				c. LENGTH OF STAY IN 1b <i>In transit</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Dr M.E. Storkel's Office</i>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chambersburg</i> 75x-3 ✓			
f. STREET ADDRESS <i>544 Wayne Ave.</i>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>JEFFREY LINN YAUKEY</i>				4. DATE OF DEATH <i>May 22 1957</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec 3 '56</i>	
9. AGE (In years last birthday) <i>5 yrs.</i>		IF UNDER 1 YEAR <i>Months 5 Days 19</i>		IF UNDER 24 HRS. <i>Hours Min.</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>			
11. BIRTHPLACE (State or foreign country) <i>Chambersburg, Pa.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>R. Linn Yaukey</i>				14. MOTHER'S MAIDEN NAME <i>Marilyn Divers</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>				16. SOCIAL SECURITY NO. <i>None</i>			
17. INFORMANT <i>Ruth Yaukey</i>				Address <i>544 Wayne Ave.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congenital Heart Disease</i> <i>754.4</i> DUE TO <i>(absence of Rt. Ventricle)</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>None</i> DUE TO (c) <i>None</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <i>No</i>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>None 19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i>None</i>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	
20f. (City or town) <i>None</i>				(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>D.D. Caples</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>D.D. CAPLES, M.D.</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>May 25/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Chambersburg Pa.</i>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.F. Elinson</i>				ADDRESS <i>Rustertown, Md.</i>		24a. REC'D BY REGISTRAR <i>5-22-57</i>	
24b. REGISTRAR'S SIGNATURE <i>Mary B. Elvin</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 1

1957

RECEIVED

5015

CERTIFICATE OF DEATH

05003

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yrlmth19dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Virginia Middle Abramo Last Zanti		4. DATE OF DEATH Month May Day 15 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1892
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR: Months 65 Days 15 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy ✓	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) generalized arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 16 , 19 54 , to May 15 , 19 57 , that I last saw the deceased alive on May 15 , 19 57 , and that death occurred at 6:00 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 5-15-57			
ACTUAL SIGNATURE Stella Wachslar M.D.		PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF May 18 57	
22c. NAME OF CEMETERY OR CREMATORY New-Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore 29. Md	
23. FUNERAL DIRECTOR'S SIGNATURE H. H. WITZKE ADDRESS 4101 EDMONDSON AVE MD		24a. REC'D BY REGISTRAR MAY 22 '57 DATE	
24b. REGISTRAR'S SIGNATURE W. H. Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's signature, burial, cremation, or removal, and in any event within 24 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05004

5916

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. LENGTH OF STAY IN 1b 3 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Filomena Middle Zappacosta Last May		4. DATE OF DEATH Month May Day 3 Year 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/20/1884
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Italy	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.M.	
13. FATHER'S NAME Peter Agostini		14. MOTHER'S MAIDEN NAME Maria Callani	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-10-9952	
17. INFORMANT Mrs. Anna Flaccomio		Address 208 E. Belvedere Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio- DUE TO (c) Renal Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 8 Days 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 442X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1954 to May 3, 1957 , that I last saw the deceased alive on May 2, 1957 , and that death occurred on May 3, 1957 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		ADDRESS (Street, city or town, state) 2501 York Rd - Towson Md	
PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.		DATE SIGNED 5/3/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/6/57	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		ADDRESS 5305 Harford Road #14	
24a. REC'D BY REGISTRAR 6 57		24b. REGISTRAR'S SIGNATURE Orlean	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 5, 1922		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. HIGHEST GRADE OF SCHOOL High School		10. RELIGION Methodist	
11. DATE OF DEATH May 2, 1968		12. TIME OF DEATH 10:00 AM		13. PLACE OF DEATH Memphis, Tennessee		14. CAUSE OF DEATH Gunshot wound		15. MANNER OF DEATH Homicide	
16. NAME OF PHYSICIAN Dr. J. H. Jones		17. NAME OF HOSPITAL St. Francis Hospital		18. NAME OF CORONER John Doe		19. NAME OF FUNERAL HOME ABC Funeral Home		20. NAME OF UNDERTAKER ABC Funeral Home	
21. NAME OF NEXT OF KIN Mother		22. ADDRESS 123 Main St, Memphis, TN		23. CITY Memphis		24. STATE Tennessee		25. ZIP CODE 38101	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF PHYSICIAN		28. SIGNATURE OF CORONER		29. SIGNATURE OF FUNERAL HOME		30. SIGNATURE OF UNDERTAKER	

BUREAU V. 1

MAY 6 1968

RECEIVED

5017 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

05005

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Granite				c. LENGTH OF STAY IN 1b X2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Davis Ave.				d. STREET ADDRESS Davis Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LILLIE Middle MAY Last ZEPP				4. DATE OF DEATH Month May Day 26 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 27, 1881	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Grays, Maryland	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ----		17. INFORMANT George H. Zepp - 716 Chapel Gate Lane			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 434.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE CARDIAC FAILURE DUE TO (c) myocardia				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 28 , 19 57 , to May 18 , 19 57 , that I last saw the deceased alive on May 18 , 19 57 , and that death occurred at 8:00 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Harold H. Weinberg M.D.				ADDRESS (Street, city or town, state) May 27, 1957			
PHYSICIAN'S NAME (Type) HAROLD H. WEINBERG MD				DATE SIGNED May 27, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/29/1957		22c. NAME OF CEMETERY OR CREMATORY Granite Presbyterian Cem.		22d. LOCATION (City, town, or county) (State) Granite, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost				24a. REC'D BY REGISTRAR May 29 1957			
24b. REGISTRAR'S SIGNATURE Dr. Wm. E. Martiny							

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Illegible]</p>		<p>2. SEX [Illegible]</p>	
<p>3. AGE [Illegible]</p>		<p>4. DATE OF BIRTH [Illegible]</p>	
<p>5. PLACE OF BIRTH [Illegible]</p>		<p>6. DATE OF DEATH [Illegible]</p>	
<p>7. CAUSE OF DEATH [Illegible]</p>		<p>8. MANNER OF DEATH [Illegible]</p>	
<p>9. SIGNATURE OF DECEASED [Illegible]</p>		<p>10. SIGNATURE OF WITNESSES [Illegible]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Illegible]</p>		<p>12. SIGNATURE OF CORONER [Illegible]</p>	
<p>13. SIGNATURE OF JURY [Illegible]</p>		<p>14. SIGNATURE OF JUDGE [Illegible]</p>	
<p>15. SIGNATURE OF CLERK [Illegible]</p>		<p>16. SIGNATURE OF REGISTRAR [Illegible]</p>	

BUREAU V. S.

MAY 29 1957

RECEIVED